Delivery and Performance Committee

Thu 06 February 2025, 10:00 - 12:30

Agenda

10:00 - 10:00
0 min

1. PRELIMINARY MATTERS

Agenda_D&P_ 06Feb2024v1.pdf (3 pages)

1.1. Welcome and Apologies

Verbal *Chair*

1.2. Declarations of Interest & Board Members Register of Interests

Verbal/Attached *All*

D&P_1.2_Board Members Declaration Of Interests summary 2024-25.pdf (4 pages)

10:00 - 10:00
0 min

2. CONSENT AGENDA BUSINESS

The Chair will ask if there are any items from the Consent Agenda (Item 7) that Committee Members wish to bring forward to the main agenda.

10:00 - 10:00
0 min

3. ITEMS FOR APPROVAL/DECISION/RATIFICATION

3.1. Minutes of the previous meeting held on 05 December 2024

Attached *Chair*

D&P_3.1_DRAFT_Minutes_D&P_05December2024.pdf (13 pages)

3.2. Committee Action Log

Attached *Chair*

D&P_3.2_Action Log.pdf (2 pages)

10:00 - 10:00
0 min

4. ESCALATED ITEMS

4.1. Organisational Status (NHS Wales escalation framework) Level 4 monitoring report

Verbal *Deputy Chief Executive/ Executive Director of Finance, Capital and Support Services/ Executive Director of Planning, Performance and Commissioning*

10:00 - 10:00
0 min

5. ITEMS FOR ASSURANCE

5.1. Finance Performance Report Month 09

Attached *Deputy Chief Executive/ Executive Director of Finance, Capital and Support Services*

D&P_5.1_Financial Performance Report Mth 09.pdf (19 pages)

5.2. Integrated Quality and Performance Report Month 09 Scorecard

Attached *Executive Director of Planning, Performance and Commissioning*

- D&P_5.2_Month9_IQPR_Cover_paper.pdf (7 pages)
- D&P_5.2a_IQPR_24-25_Month 9.pdf (16 pages)

5.3. Q3 Annual Delivery Progress Report

Attached *Executive Director of Planning, Performance and Commissioning*

- D&P_5.3a_Integrated Plan Q3 Progress Report Delivery & Performance Committee 29.01.25.docm.pdf (60 pages)
- D&P_5.3_Q3 Annual Delivery Plan Cover Paper 290125.pdf (16 pages)

5.4. Primary Care: Out of Hours (OOH)

- D&P_5.4_PTHB_OOH mid year performance report 2024-25.pdf (10 pages)
- D&P_5.4a_Appendix 1_Commissioning Assurance Framework Dashboard.pdf (1 pages)
- D&P_5.4b_Appendix 2_Commissioning Assurance Framework.pdf (11 pages)
- D&P_5.4c_Appendix 3_OOH Tolerance Levels.pdf (8 pages)

5.5. Six Monthly report of Continuing Health Care Costs

Attached *Deputy Chief Executive/ Executive Director of Finance, Capital and Support Services*

- D&P_5.5_Continuing Health Care Costs_January2025.pdf (10 pages)

5.6. Six Monthly Report on Catering Services

Attached *Deputy Chief Executive/ Executive Director of Finance, Capital and Support Services*

- D&P_5.6_Food Safety Compliance Assurance Report.pdf (8 pages)

5.7. Digital First Assurance Report (Mid-Year)

Attached *Executive Director of Allied Health Professions, Health Sciences and Digital*

- D&P_5.7_Digital First Assurance Report January 2025.pdf (33 pages)

5.7.1. COMFORT BREAK (15mins)

5.8. Approach to Annual Accounts

Presentation on the Day *Director of Corporate Governance & Deputy Chief Executive/ Executive Director of Finance, Capital and Support Services*

5.9. Capital and Estates Compliance Report

Attached *Deputy Chief Executive/ Executive Director of Finance, Capital and Support Services*

- D&P_5.9 Capital Estates Compliance Update January 2025.pdf (13 pages)

5.10. Committee Risk Register

Attached *Director of Corporate Governance*

- D&P_5.10_Committee Risk Report_February 2025 (January's Data).pdf (8 pages)
- D&P_5.10a_CRR001 (Financial forecast)_Jan 25.pdf (3 pages)
- D&P_5.10b_CRR002 (Financial Resources)_Jan 25.pdf (4 pages)
- D&P_5.10c_CRR003 (Resource Allocation)_Jan 25.pdf (4 pages)
- D&P_5.10d_CRR009 (Estates)_Jan 25.pdf (8 pages)

10:00 - 10:00
0 min

6. ITEMS FOR DISCUSSION

There are no items for inclusion within this section

10:00 - 10:00
0 min

7. CONSENT AGENDA

7.1. Endoscopy Update (including JAG accreditation)

Attached *Executive Medical Director*

D&P_7.1_Endoscopy JAG Position Update 2024.pdf (5 pages)

7.2. Internal Audit Reports: a) Core Financial Systems, Treasury Management b) Board and Committee Structure/ Effectiveness c) Capital Systems d) Energy Management

Attached *Director of Corporate Governance*

D&P_7.2_PTH-2425-15 Core Financial Systems - Treasury Management Final Internal Audit Report.pdf (19 pages)
D&P_7.2a_PTH-2425-02 Board Effectiveness Final Report.pdf (6 pages)
D&P_7.2b_PTHB-SSU-2425-26 Capital Systems.pdf (12 pages)
D&P_7.2c_PTHB-SSU-2425-25 Energy Management.pdf (10 pages)

7.3. D&P Work Programme

Attached *Director of Corporate Governance*

D&P_7.3_2024-25 D&P work programme.pdf (1 pages)

7.4. PTHB Glossary

Attached *Director of Corporate Governance*

D&P_7.4_Powys Teaching Health Board Glossary January 2025.pdf (5 pages)

10:00 - 10:00
0 min

8. OTHER MATTERS

8.1. Any Other Urgent Business

Verbal *Chair*

8.2. Items to be brought to the attention of the Board and/or other Committees

Verbal *Chair*

8.3. Committee Reflections

Verbal *All*

8.4. Date of the next meeting: 01 May 2025 via Microsoft Teams

8.5. Representatives of the press and other members of the public shall be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest

DELIVERY AND PERFORMANCE COMMITTEE

THURSDAY 06 FEBRUARY 2025
10:00-13:30
VIA MICROSOFT TEAMS
CHAIR: RHOBERT LEWIS

GIG CYMRU NHS WALES
Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

AGENDA				
Time	**Item**	**Title**	**Attached / Verbal**	**Owner**
	1	**PRELIMINARY MATTERS**		
10:00	1.1	Welcome and Apologies	Verbal	Chair
	1.2	Declarations of Interest • Board Members Register of Interests	Verbal/ Attached	All
	2	**CONSENT AGENDA BUSINESS**		
The Chair will ask if there are any items from the Consent Agenda (Item 7) that Committee Members wish to bring forward to the main agenda.				
	3	**ITEMS FOR APPROVAL / DECISION / RATIFICATION**		
	3.1	Minutes of previous meeting held on 05 December 2024	Attached	Chair
	3.2	Committee action log	Attached	Chair
	4	**ESCALATED ITEMS**		
10:05	4.1	Organisational status (NHS Wales escalation framework) - Level 4 monitoring report	Verbal	Deputy Chief Executive/ Executive Director of Finance, Capital and Support Services / Executive Director of Planning, Performance and Commissioning
	5	**ITEMS FOR ASSURANCE**		
10:25	5.1	Finance Performance Report Month 09	Attached	Deputy Chief Executive/ Executive Director of Finance, Capital and Support Services
10:40	5.2	Integrated Quality and Performance Report Month 09 scorecard	Attached	Executive Director of Planning, Performance and Commissioning
11:00	5.3	Q3 Annual Delivery Progress Report	Attached	Executive Director of Planning, Performance and Commissioning
11:15	5.4	Primary Care: Out of Hours (OOH)	Attached	Executive Director of Primary, Community Care and Mental Health
11:30	5.5	Six monthly Report on Continuing Heath Care costs	Attached	Deputy Chief Executive/ Executive Director of Finance,

				Capital and Support Services
11:40	5.6	Six monthly Report on Catering Services	Attached	Deputy Chief Executive/ Executive Director of Finance, Capital and Support Services
11:50	5.7	Digital First Assurance Report (Mid-year)	Attached	Executive Director of Allied Health Professions, Health Sciences and Digital
12:00 15min	**COMFORT BREAK**			
12:15	5.8	Approach to Annual Accounts	Presentation/ Verbal	Director of Corporate Governance/ Deputy Chief Executive/ Executive Director of Finance, Capital and Support Services
12:25 10min	5.9	Capital and Estates Compliance Report	Attached	Deputy Chief Executive/ Executive Director of Finance, Capital and Support Services
12:35 10min	5.10	Committee Risk Register	Attached	Director of Corporate Governance
	6	**ITEMS FOR DISCUSSION**		
There are no items for inclusion within this section.				
	7	**CONSENT AGENDA**		
	7.1	Endoscopy Update to include JAG accreditation *(verbal update following PPPH Committee)*	Attached	Executive Director of Primary, Community Care and Mental Health
	7.2	Internal Audit Reports: **(For Assurance**) • Core Financial Systems – Treasury Management *(Substantial Assurance)* • Board & Committee Structure / Effectiveness *(Substantial Assurance)* • Capital Systems *(Reasonable Assurance)* • Energy Management *(Reasonable Assurance)*	Attached	Director of Corporate Governance

	7.3	Committee Work programme **(For Information)**	Attached	Director of Corporate Governance
	7.4	PTHB Glossary **Purpose:** For Information	Attached	Director of Corporate Governance
	8	**OTHER MATTERS**		
	8.1	Any other urgent business	Verbal	Chair
	8.2	Items to be brought to the attention of the Board and/or other Committees	Verbal	Chair
	8.3	Committee reflections	Verbal	All
	8.4	Date of the next meeting: 01 May 2025 via Microsoft Teams		
8.5 The Chair, with advice from the Director of Corporate Governance/Board Secretary, has determined that the following items include confidential or commercially sensitive information which is not in the public interest to discuss in an open meeting at this time. The Board is asked to take this advice into account when considering the following motion to exclude the public from this part of the meeting: Motion under Section 1(2) Public Bodies (Admission to Meetings) Act 1960 ***"Representatives of the press and other members of the public shall be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest"***				
13:05	8.6	Welcome and apologies	Verbal	Chair
	8.7	Declarations of interest	Verbal	All
	8.8	Minutes from the previous In-Committee Meeting	Attached	Chair
13:10	8.9	Corporate Risk Register	Attached	Director of Corporate Governance

Powys Teaching Health Board is committed to openness and transparency and conducts as much of its business as possible in a session that members of the public are normally welcome to attend and observe.

Meetings are currently held virtually, should you wish to observe a virtual meeting of a committee, please contact the Director of Corporate Governance at PowysDirectorate.CorporateGovernance@wales.nhs.uk at least 24 hours in advance of the meeting in order that your request can be considered on an individual basis.

Papers for the meeting are made available on the website in advance and a copy of the minutes are uploaded to the website once agreed at the following meeting.

Whilst Committee meetings are not public meetings, questions are invited and welcome from members of the public – pleased submit these at least 48 hours in advance of the meeting so a response can either be incorporated into the Board meeting or be provided directly to the requester. Please submit any questions to PowysDirectorate.CorporateGovernance@wales.nhs.uk.

POWYS TEACHING HEALTH BOARD - REGISTER OF DECLARATION OF INTERESTS 2024/25

Updated: January 2025

Position	Name	Nature of Interest	Nature of Declaration	Relevant Dates from	Relevant Dates to	Description of Declaration	Comment	Date Returned	Last day in Powys Teaching Health Board
INDEPENDENT MEMBERS									
PTHB Chair	**Carl Cooper**	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies	2017	2025	Board Member, Social Care Wales	Remunerated Public Appointment	03/06/2024	
		Spouse/Partner/Other	Ownership or part ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with PTHB	2018	Ongoing	Sole Trader, Mandy Williams, Consulting	NIL		
Vice Chair	**Kirsty Williams**	Personal	A position of authority in a Charity of Voluntary Body in the field of health and/or social care	May-22	Current	Deputy Director Samaritans Powys	None	22/05/2024	
			Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	Nov-22	Current	ILEP- A Subsidory of Cardiff University	None		
			Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice	Feb-24	Ongoing	Commissioner for South Wales Fire and Rescue	Ministerial Appointment		
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Independent Member (General)	**Rhobert Lewis**	Personal	Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	Nov-21	Current	Chair NPTC Group of Colleges	NIL	08/04/2024	
				Sep-23	Current	Chair Confederal Governance UWTSD	NIL		
				Nov-21	Current	Member of National Assesmbly of Wales Cross-Party Group on STEMM	NIL		
		Spouse/Partner/Other	NIL	NIL	NIL	NIL			
Independent Member (Trade Union)	**Cathie Poynton**	Personal	NIL	NIL	NIL	NIL	NIL	02/04/2024	
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Independent Member (Information and Technology)	**Ian Phillips**	Personal	Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	01-Aug-21	Current	Independent Chair Welsh Kidney Network	Remunerated	08/04/2024	22/08/2024
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Independent Member (finance)	**Steve Elliot**	Spouse/Partner/Other	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	04/02/2024	Current	Director of Oshi's World Private Limited Company	NIL	19/08/2024	
		Personal	Ownership or part ownweship of private companies, businesses or consultancies likely or possibly seeking to do business with PTHB	22/09/2023	31/03/2024	Special Advisor (Finance) to Powys tHB Audit and Delivery and Performance Committees	Yes		
		Spouse/Partner/Other	A position of authority in a Charity or Voluntary Body in the field of health and/or social care	04/02/2024	Current	Trustee of Oshi's World Charity	NIL		
Independent Member (General)	**Ronnie Alexander**	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	2012	Current	Director of RA and CJ Consulting Limited	Dividend Payment only	15/08/2024	
			A position of authority in a Charity or Voluntary Body in the field of health and/or social care.	2017	Current	Member of Finance, Risk and Audit Committee Hafod/Hendre Housing Association	£2500.00 per annum		
			Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests	Mar-21	Current to Dec-27	Personal: Independent Monitoring Authority (IMA) – Non Executive Director	£7500.00 per annum		
		Spouse/Partner/Other	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	2017	Current	Director of RA and CJ Consulting Limited	Dividend Payment only		
Independent Member (University)	**Simon Wright**	Personal	Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.	2015	Current	Personal: Academic Registrar, Cardiff University-Various Healthcare Programmes	Salaried Employment	08/07/2024	
		Spouse/Partner/Other	A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	2001	Current	Sister: Senior Operational Manager, Milestone Trust, Bristol	Salaried Employment		

			Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.	2021	Current	Spouse: District Nurse, Cardiff and Vale UHB	Salaried Employment		
Independent Member (Third Sector)	**Jennifer Owen Adams**	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	Jun-16	Ongoing	Member (not a NED) of Glas Cymru the holding company of Dwr Cymru/Welsh Water	None	30/04/2024	
			Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests	Apr-14	Ongoing	Trustee of Impelo Dance CIO	None		
				Jul-05	Ongoing	Chair Public Services Board Scrutiny Committee	None		
		Spouse/Partner/Other	Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests	2013	Ongoing	Brother - Senior Manager Freedom Leisure (Lead responsibility for Swansea and South Powys).	NIL		
Independent Member (Local Authority)	**Christopher Walsh**	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.			Member of Community Speed Wath Group Member of Society Genealogists Associate Member of the Association of Genealogists and Registered Archivists	NIL	09/09/2024	
			Ownership or part ownweship of private companies, businesses or consultancies likely or possibly seeking to do business with PTHB		Ongoing	Sole Trader/Owner of Celebratory Gifts Heraldic Names Sole Trader/Owner:CTW Genealogy Research and Owneer:Property in the County of Powys	NIL		
			A position of authority in a Charity or Voluntary Body in the field of health and/or social care.		Ongoing	Elected Member Powys County Council •Trustee/Chair: Brecon University Scholarship Fund •Brecon Town Council Elected Member •Governor of Priory Church in Wales School •Member Brecon Beacons National Park Authority SDF & Grant Advisory Panel	NIL		
			Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.		Ongoing	•Member of Royal College of Nursing •Registered Member of Nursing and Midwifery Council	NIL		
			Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.		Ongoing	Labour Party	NIL		
Independent Member (Capital)	**Michael Giannai**	Personal	Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	2019	Current	Chair of the Board of Social Care Wales (Welsh Government Sponsored Body).	Remunerated	01/04/2024	
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Independent Member	**Ian Thomas**	Personal	Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	Jan-23	Current	Family Fund (UK Charity)	NIL	09/01/2025	
				Jun-24	Currne t	Family Fund Business Services (FFBS)	NIL		
EXECUTIVE MEMBERS									
Chief Executive Officer	**Hayley Thomas**	Personal	NIL	NIL	NIL	NIL	NIL	30/05/2024	
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Executive Director of Planning, Performance & Commissioning	**Stephen Powell**	Personal	NIL	NIL	NIL	NIL	NIL	03/07/2024	18/10/2024
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Executive Director of Finance, Capital and Support Services	**Pete Hopgood**	Personal	NIL	NIL	NIL	NIL	NIL	22/05/2024	
		Spouse/Partner/Other	A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	Ongoing	Ongoing	Partner is Finance Manager working in SBUHB	Not Relevant		

Executive Director of Allied Health Professions, Health Science and Digital	**Claire Madsen**	Personal	Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.	07-Jan-19	Current	Occasional Lecturer for University of West of England.	Hourly rate	02/04/2024	
			Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	10-Jun-05	Current	Member of the The Chartered Society of Physiotherapy	NIL		
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Executive Director of Nursing, Quality, Women and Family Health	**Claire Roche**	Personal	A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	2018	Current	Member of the Royal College of Nursing	NIL	22/08/2024	
				1994	Current	Member of the Royal College of Midwifery			
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Executive Medical Director	**Kate Wright**	Personal	Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.	01-Aug-91	Current	Member of the British Medical Association		12/08/2024	
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Executive Director of People and Culture	**Debra Wood Lawson**	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	01-Nov-24	Current	Non Executive Board Director - Cadarn Housing Group Limited (Powys is a zonal partner)	NIL	18/11/2024	
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Executive Director of Public Health	**Mererid Bowley**	Personal	Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	NIL	NIL	Member of Faculty of Public Health	NIL	23/05/2024	
		Spouse/Partner/Other	Ownership or part ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with PTHB.	NIL	NIL	Husband works for Mitie Engineering who hold contracts/work with some NHS bodies/organisations. Shares held by husband and myself and Mitie Company	NIL		
Interim Executive Director of Operations	**Joy Garfitt**	Personal	NIL	NIL	NIL	NIL	NIL	No change from 2023 submission	30/09/2024
		Spouse/Partner/Other	A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	2012	Current	Spouse employed by PTHB within Mental Health Department	NIL		
Director of Corporate Governance / Board Secretary	**Helen Bushell**	Personal	Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.	Nov-21	Current	School Governor – primary school (Bridgend Local Authority)	Not remunerated	03/06/2024	
		Spouse/Parter or other Relative	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	Sep-16	Current	Board Diretor and Chair of the Board Cadarn Housing Ltd (Powys is a zonal partner)	Remunerated part time role, 2-4 days per month		
			A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	Jul-24	Oct-24	Spouse member of the PTHB Bank working occasionally for the Health Board	Paid per hour/day of work		
			Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	Sep-22	Current	Public Appointment - Youth Work strategy and implementation Board - Oct 22 - Sept 24	Remunerated 2-4 days per month		
Associate Director of Capital and Estates	**Wayne Tannahill**	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	1996	2016	Director of Pembrokeshire Surveyors Ltd. Sole proprietor, small architectural business, made dormant April 2016 (formally closed April 2017)		24/04/2024	
		Spouse/Parter or other Relative	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	1996	2016	Daughter Kate was Company Secretary			
Director of Strategic Improvement and Transformation	**Lucie Cornish**	Nil	Nil	Nil	Nil	Nil	Nil	13/11/2024	
Executive Director of Planning, Performance & Commissioning	**Nicola Johnson From 07/10/24**	Nil	Nil	Nil	Nil	Nil	Nil	16/10/2024	

Executive Director of Primary, Community Care and Mental Health	**Elaine Lorton From 30/09/2024**	Personal	A position of authority in a Charity or Voluntary Body in the field of health and/or social care.	Nov-19	Current	Chair – West Wales Care & Repair	Nil	17/10/2024	
				Apr-24	Current	Independent Member – ateb	£2,960 Per Annum		

DELIVERY & PERFORMANCE COMMITTEE

UNCONFIRMED MINUTES OF THE MEETING HELD ON THURSDAY 05 DECEMBER 2024, VIA MICROSOFT TEAMS

Members Present:		
Rhobert Lewis	RL	Independent Member (General) Chair
Kirsty Williams	KWi	Independent Member (PTHB Vice-Chair)
Cathie Poynton	CP	Independent Member (Trade Union)
Steve Elliot	SE	Independent Member (Finance)
In Attendance:		
Pete Hopgood	PH	Deputy Chief Executive and Executive Director of Finance, Capital and Support Services
Elaine Lorton	EL	Executive Director of Primary, Community Care and Mental Health Services
Claire Madsen	CM	Executive Director of Allied Health Professions, Health Sciences and Digital Services
Nicola Johnson	NJ	Executive Director of Planning, Performance and Commissioning Services
Hayley Thomas	HT	Chief Executive Officer
Claire Roche	CR	Executive Director of Nursing, Quality, Women and Family Health
Kate Wright	KW	Executive Medical Director
Helen Bushell	HB	Director of Corporate Governance/Board Secretary
Carl Cooper (Observing)	CC	PTHB Chair
Apologies for Absence:		
Ronnie Alexander	RA	Independent Member (Chair)
Mick Giannasi	MG	Independent Member (General)

PRELIMINARY MATTERS
1.1 WELCOME AND APOLOGIES FOR ABSENCE (D&P/24/074)
RL welcomed everyone to the meeting. Apologies for absence were noted as recorded above. RL confirmed he was chairing the meeting in the absence of RA.
1.2 DECLARATIONS OF INTERESTS (D&P/24/075)
No declarations on interest were received in addition to those already recorded on the register.
2. CONSENT AGENDA BUSINESS (D&P/24/076)
The Chair asked members if they wish to bring forward any items from the Consent agenda to the main agenda. No items were raised.
3. ITEMS FOR APPROVAL/DECISION/RATIFICATION
3.1 MINUTES OF THE PREVIOUS MEETING (D&P/24/077)
The minutes of the meeting held on 22 October 2024 were DISCUSSED. The following amendments were made:

Steve Elliott sent apologies to the In-Committee on 22 October 2024.

(D&P/24/064) - 'to engage with patients and stakeholders regarding experiences of General medical service (GMS) access'

Can clarity be provided on the delivery of GMS access as part of the Health Boards commitment to the plan?

EL confirmed that all GP practices undertake population surveys with further conversation needed with Llais to understand the presenting concerns. Powys are awaiting guidance from Welsh Government regarding actions that are to be undertaken regarding access. Feedback would be provided to the committee at the February meeting with a brief discussion with the Committee Chair prior to this meeting.

Action: Executive Director of Primary, Community Care and Mental Health.

(D&P/24/065) – 'Are Powys comfortable that Clusters are achieving what is expected as an organisation'

When is it anticipated that we understand what the service wants and ensure the appropriate functions are in place?

EL highlighted that appropriate functions are not fully in place as yet given the evidence, outcomes and projects implemented by Clusters. Recent engagement with Town Councils and the Local Authority had highlighted opportunities for change, recognising a broader discussion is required with Cluster Leads regarding place-based planning and how this is aligned to health board processes. It was agreed that an annual update would be presented to Committee members to review the system of Clusters.

Action: Executive Director of Primary, Community Care and Mental Health

To what extent is Powys learning from other Health Boards in terms of Clusters operating across rural areas?

EL explained she had led this work across Hywel Dda University Health Board for a number of years and across practice-based commissioning in England. Learning and experience from these roles would be implemented into the plan across Powys.

The Committee **CONFIRMED** the minutes of the meeting held on 22 October 2024, subject to the agreed amendments.

3.2 COMMITTEE ACTION LOG (D&P/24/078)

HB introduced the Action Log that recorded updates with the following information provided:

D&P/24/062a – *Provide analysis on the positive variance income from service providers*

PH explained that additional funding had been allocated from HEIW in relation to the ongoing training with benefits evident across the Community Services group. The data was shared with members of the Committee.

The following actions had been completed and were AGREED to be closed:

D&P/24/063
D&P/24/063a
D&P/24/063b
D&P/24/063c

The Committee **RECEIVED** the Action Log updates and noted the closed items.

4. ESCALATED ITEMS

4.1 ORGANISATIONAL STATUS (NHS WALES ESCALATION FRAMEWORK) ENHANCED MONITORING REPORT (D&P/24/079)

PH confirmed that Powys had been placed into an increased level escalation status by Welsh Government, with PTHB placed into Level 4 of the framework (targeted intervention) for Strategy, Planning and Finance. The increased escalation is largely due to an unsupportable Integrated Medium-Term Plan (IMTP) and deficit budget.
Products implemented locally are:

- Monthly IQPD meeting, previous two meetings are included within the Committee papers
- Biannual joint executive team with Welsh Government
- Finance – monthly finance reporting and escalation action plan in place
- Planning – regular reporting and draft maturity matrix in place

Detail on the roles and responsibilities against the criteria set by Welsh Government along with assurance dashboards was highlighted. NJ highlighted the following key themes:

- The Health Board awaits a follow up letter regarding the de-escalation criteria for Level 4 which is expected in December;
- PTHB remains in routine monitoring for all other domains of escalation within the Welsh Government Framework with good progress against the delivery of planning and performance;
- A baseline assessment had been undertaken on the planning maturity matrix as part of the de-escalation criteria and following consideration at the PTHB Board , this is due to be submitted to Welsh Government and;
- A letter had been received following a recent Joint Executive Team (JET) meeting which noted positive progress.

HT highlighted that as part of the learning process, plans are ongoing for Welsh Government colleagues to attend a Board Development session to discuss the escalation status. Following discussions, feedback would be provided to the committee on how the organisation plans to respond to the escalation status.
Action: Chief Executive Officer

Has Powys received dialogue of what the Clinical Services Plan looks like?
Welsh Government are seeking for a medium to long service plan for service sustainability. Powys had set their clinical services strategy in 2017 across the shared Health and Social care system.

The Committee **RECEIVED** the report as part of a package of assurance that PTHB continues to report as required in relation to its organisational escalation status. The Committee also **NOTED** the latest position on organisational escalation status for PTHB.

5.ITEMS FOR ASSURANCE

5.1 FINANCE PERFORMANCE REPORT MONTH 07 (D&P/24/080)

PH presented the report and noted the same report has been presented to the Board last week with no additional changes. The following key areas were highlighted:

- Powys Teaching Health Board (PTHB) continue to monitor against the current year-end deficit plan of £22.9m which continues to be unsupported;

- At month 7, there is a £17.182m overspend against the planned year to date deficit of £13.387m giving the Health Board an operational overspend of £3.794m;
- The year end forecast remains in line with the resubmitted plan at £22.948m, but this is not without risk;
- The capital resource limit for 2024/25 is £12.647m. To date £0.776m had been spent;
- Pressure areas continue across Continuing Health Care (CHC) linked to the number of packages received had been higher than anticipated against agency spend.
- Secondary Care delays- Discharge delays from community and district general hospitals (DGH) due to capacity and performance challenges with Adult Social Care Services has caused an increased pressure on the Health Board of £5.5m.
- Further work is being considered to mitigate actions to enable delivery to improve the financial position;
- Additional funding had been made available cross all Heath Boards regarding inflation pressures of Prescribing, Secondary Care Medicines and Packages of Care across CHC and FMC. Based upon Powys' population, a total allocation of £2.178m would be received;
- A total of £5m had been allocated across Wales given the pressures of English performance impacts on 104 week waits.

Committee members sought assurance by asked the following questions:

What is the rationale for the significant increase in social care hospital delays comparable to last year?
PH explained that monitoring and reporting of this had improved with assessment delays being reported as an addition this year. Given pressures across the system, Powys continue to work with the Local Authority (LA) to mitigate actions and continue to monitor those challenged areas.

Is the additional funding recurrent?
The funding aligns a number of conditions with the assumption that should these be met, the funding would be re-current.

The agency E-rostering issues highlighted in previous reports is not referred to within the report and is the Agency spend more real time accurate?
PH explained this had been closely monitored with issues considerably reduced and therefore no concerns are to be reported.

Is there opportunity to think about a different long term CHC service model?
PH explained that action across CHC is multilayered which links with the Value and Sustainability Board. Work is being undertaken to review capacity and demand to ensure this is aligned, recognising the constraint of vacancies across the service.

Would Powys be liable for further treatment arrangements, should a patient outside of Powys be placed within a community hospital?
PH explained that the responsibility is based upon the residency who would be liable for the CHC costs. EL acknowledged the potential risks associated with nursing home beds and the challenge and need to balance into future planning. A paper is scheduled to be presented at Executive Committee to review the scope of Childrens options for CHC led by the Director of Nursing, Quality, Women and Family Health

The Committee:

- **RECEIVED** the financial report and took **ASSURANCE** that the organisation has effective financial monitoring and reporting mechanisms in place.
- **NOTED** the current increased risk of achieving the projected in year forecast for 2024/25.
- **NOTED** the Board recognised on the 27 November that further ongoing in year mitigations would need to be delivered to achieve the in-year forecast.

5.2 INTEGRATED QUALITY AND PERFORMANCE REPORT MONTH 07 LITE (D&P/24/081)

NJ provided an update on the latest performance position, highlighting that Month 06 of the Performance report had been considered by the Board last week.
The following key areas across Performance were highlighted:

- Overall Performance across Powys had maintained;
- Improvement across Mental Health Services is anticipated within the next reporting cycle;
- Neurodevelopmental Services for Children remains in escalation, improvement is anticipated given the work being undertaken;
- Cancer waiting times remain a challenge;
- Planned Care remained compliant with Referral to treatment time (RTT) measures.

Committee members observed: What leverage does the organisation have as a commissioner to Welsh providers on ways that can be improved. Members recognised that further discussion would be undertaken at the next meeting following receipt of new data.

The Committee **DISCUSSED** the content of the Integrated Quality and Performance report, and **ASSURANCE** was provided that the Health Board has appropriate systems in place to monitor performance and respond to relevant issues.

5.3 COMMUNITY PHARMACY ANNUAL REPORT (D&P/24/082)

KW introduced the report which demonstrated significant progress over the 12-month period to strengthen performance and quality contract monitoring across Community Pharmacy. The position conveys fragilities and challenges across the system with the service under review of its delivery. Monitoring the spend against the monies allocated to community pharmacy continues to be a priority.

The following themes were highlighted:

- Increased trend of contractors submitting requests to reduce their opening hours.
- Electronic subscription services setup in four Practices with additional three onboarding next year;

Committee members asked the following questions:

What is the cause of fragility across the service?
JS explained that National Funding remains a challenge across England and Wales with difficulties to recruit to Pharmacists into Powys. GP contracts remain an issue with core hours declared by the Practice with minimal input from the Health Board.

Is there a plan for all Pharmacies to move into the system of 56 day prescribing other than those managed by GP Surgeries?

JS noted that 79% of the Powys population is registered with a dispensing practice. There would be a loss of income should all Practices move to 56 day prescribing due to the nature of population demand. The rationale for the 56-day prescribing system to be in place, is to allow Pharmacists to focus on clinical duties which continues to remain a challenge in Powys.

Is there data available for uptake across Clinical Community Pharmacy?
JS confirmed that Clinical Community Pharmacy services are monitored on a monthly basis to review uptake and act where imbalances may occur. This data is also shared with contractors to ensure transparency of demand and work undertaken across the Organisation.

Given the absence of Pharmacy Lead roles, is there a mechanism to ensure Community Pharmacy feed into Cluster planning?
Currently, both Mid and South Clusters have no Community Pharmacy lead, although recruitment is continued to be encouraged working with Welsh Government and Independent Wales. The main challenge for Powys is to identify designated prescribing practitioners to support training. It was noted that two additional prescribing Pharmacists are due to begin in post in the forthcoming financial year and it is anticipated that figures will begin to increase.

The Executive Medical Director congratulated the extensive work undertaken across the Pharmacy team regarding the 56-day prescribing system. The committee recognised the challenges and importance of contractual change, and the service is awaiting a response from Welsh Government regarding mitigation for practices.

The Committee:

- **RECEIVED** the Community Pharmacy Performance Report **NOTING** the progress made and were **ASSURED** that a clear understanding of the challenges in community pharmacy and are taking proactive steps to address them.

5.4 PRIMARY CARE: GENERAL DENTAL SERVICES (GDS) (D&P/24/083)

EL provided members with an update on the General Medical Services Commissioning Assurance Framework process applied to the 2023/24 contract year. Changes introduced in the national GMS Unified Contract, outlined detail from PTHB GMS Commissioning Assurance Framework from 1st April 2023 – 30th September 2023 and GMS Unified Contract Assurance Framework from 1st October 2023 – 31st March 2024. The following key themes were highlighted:

- Mid-year reviews are ongoing and 100% will be concluded by 29 November 2024,
- Non-recurrent contract reductions agreed for 2024/25 include My Dentist Newtown and My Dentist Welshpool. Discussions ongoing regarding a permanent contract rebases.
- Non-recurrent contract increases agreed for Clifton Dental Practice and Llansantffraid Dental Practice.
- A new Mobile Dental Unit located in Hay-on-Wye provides NHS dental services in the area enabling easy access to vulnerable groups. Any patients that are highlighted as 'high needs' or 'vulnerable' are referred for ongoing NHS access within Brecon Community Dental Service.

Access to general dental services (GDS) continues to be a local and national challenge. Supporting patients to access appropriate GDS provision continues to be a high priority for Powys. The Powys dental waiting list has recently transferred to the national Dental Access Portal (DAP) which is a Welsh Government initiative that shows accurate data of the NHS dental access issues being faced in Wales. Powys had been chosen as the pilot site for the DAP to check whether patients still required access to an NHS dentist. This is ongoing, but the majority of patients have now been transferred to the DAP.

Members asked the following questions:

What is the rationale for those practices that are under performing?
EL explained that Workforce challenges remain a high priority across dental services in addition to the risks of prioritisation of Private dental work over NHS work is seen to have increased.

4,876 patients are on an NHS dental waiting list, is this seen to be increasing?
EL would seek confirmation of the data trend and an email would be circulated to members to confirm the trend over the last 3 years to specify the number of patients waiting for routine dental care to date.
Action: Executive Director of Primary, Community Care and Mental Health

Is there any scope to support service family's access to dental care whilst temporarily living in Powys?
EL explained that this would need to be reviewed with two available routes for access through Community Dental Services for Children and Young People and Urgent dental access.
Action: Executive Director of Primary, Community Care and Mental Health

CC shared with the committee that he had recently visited the mobile dental unit situated within Hay-On Wye which had reported to have seen almost all dental patients on a waiting list from the immediate region with the intention to move the unit to various locations across Powys with a revisit within 12 months. CC explained the positive impact of the service and was encouraged by the team's enthusiasm.

The following observations were made:
All Children and young people receive NHS dental services, although it was noted that stats show 49% of individuals receive treatment. The Committee recognised the stats did not represent a realistic reflection and would be reviewed by the Executive Director of Primary, Community Care and Mental Health. EL explained that there remains a strong cohort of patients that will not access NHS dental services, and this would also be reviewed.
Action: Executive Director of Primary, Community Care and Mental Health

Can clarity be given against the total forecast for last year against the £596,000 underspend with £419,000 remaining and are these payments that have been made, that need to be recovered?
PH clarified that the underperformance is a benefit to the Organisation which is contributed to the financial performance and the transactions related to this.

How does the NHS Business Services Authority (BSA) Clinical Advisory team work, and how are referrals made to the team if concerns are raised regarding operations within a particular practice?
KW confirmed that the Dental Director carries out a number of different audits across all practices. Should concerns be raised, this is alerted to the Medical Director with additional audits undertaken.

HT expressed that further work is required to understand how to triangulate audits undertaken contractually of quality improvement. It was agreed that a report would be considered at the Patient Experience, Quality and Safety Committee in the near future to fully understand how quality is measured from a general and community dental perspective.
Action: Executive Director of Primary, Community Care and Mental Health

The Committee **RECEIVED** the update report and took **ASSURANCE** that the General Dental Services Commissioning Assurance Framework monitoring process is providing the required information on dental contract management.

5.5 CAPITAL PROGRAMME DELIVERY AND PIPELINE OVERVIEW (D&P/24/084)

WT provided members with an overview on the current status of the Organisations Capital Programme. The availability of Welsh Government (WG) funding, both revenue and capital, is recognised as a significant challenge. Whilst the 2024/2025 capital allocation for PTHB, at over £12M, is the highest for any years, there are concerns around the future position as the outcome of the WG Capital Prioritisation Process is yet to be announced – this recognised the disparity between the Health Board bids to WG for £6.7Bn over 10 years and the circa £400M per annum allocation.

Powys is seeking Capital investment wherever possible and is currently on track to meet the anticipated spend profile for the year, it had been recognised that the risks to delivery include resource availability across the Capital team. Noted 20 of the 51 projects are complete, however pressures on the second half of the financial year spend cycle is significant as capital is released from various sources.

The criticality of the Routemap work had been recognised and the importance of Capital expenditure to enable activity. It is vital that any capital requirements for next financial year and beyond are understood as the new Capital Programme planning cycle approaches. PH thanked the Estates team for the hard work undertaken to date given the challenges faced.
Members asked the following questions:

Are the Capital and Estates plans being integrated into the master plan?
Yes.

Where money is limited, how will this affect the health board to achieve objectives in terms of decarbonisation?
Powys has £4m investment for refit with work underway across multiple sites delivering £3.6m within this financial year, this is anticipated to see a significant benefit of energy savings. Within the Estates and Facilities Advisory Board (EFAB), there is specific funding of £6m for bids set by Welsh Government to supplement refit funding on an invest to save basis. Welsh Government expect health boards to work with Refit to reduce Co2.

How does the repayment mechanism work in terms of Refit and is it anticipated that EFAB funding would be available for the North Powys scheme?
There is a payback period over nine years with anticipated savings per annum is written by EFAB framework which is underwritten and paid back by the company.
Powys are working closely with Welsh Government to review opportunities as part of the campus which is preventative care and at the forefront of the bidding process. Complex discussions are ongoing regarding financial benefits which are distributed is various ways.

Where is the Estates strategy placed within the planning for the Integrated Medium-Term Plan (IMTP)?
Significant work had been undertaken regarding Transformation activity and a paper is scheduled at Executive Committee on 18 January 2025 regarding how Estates links into the broader transformation activity. WT explained it is critical to define what the health boards vision is for the future and the importance to recognise the agile nature of supporting the Transformation agenda from Estates and Capital perspective.

When is it expected that the IRCF bid would be submitted?
The IRCF bid for fees would be submitted through business case progression timelines with the aim to submit during summer 2026 and an estimated completion date of IRCF hub 2027/2028. The benefits of the scheme will deliver within its entirety.

The SOC submitted in 2022 is not yet supported, is there a risk developing a plan which doesn't succeed due to the holistic vision for North Powys isn't approved?
There is a risk but it is important to follow the recognised business case process.

The committee recognised Capital as an enabler which follows Transformation and Service development. Noted the Regional Partnership Board (RPB) is now in a better integrated place to support the Health and Care strategy.HT added that there is a need to review various scenarios of availability of Capital which will require Board discussion regarding how a response is put forward as the service strategy is reviewed.

The Committee **NOTED** the update and associated risks and took **ASSURANCE** in respect of the delivery of the programme of activity.

5.6 COMMUNICATIONS AND ENGAGEMENT REPORT (D&P/24/085)

HB introduced the report in which each Committee of the Board would receive a Communications and Engagement report specific to each Committee at various quarters of the year. An overview was presented to members of the team's delivery during Q2 2024/25 and a look forward to Q3 2024/25. Key highlights during Q2 included:

- Intensive programme of work to support engagement and decision-making on a number of temporary service changes, a continued programme of environmental improvements, and further expansion of our use of govDelivery to support targeted and personalised communication, and a focus on wellbeing and early help & support including through smoking cessation, vaping, SilverCloud.
- Work programme delivery continued to be driven by the organisation's principal priorities, risks and reputational impact issues.
- The health board continues to deliver and/or support a range of campaigns. Active planning for the future remains in place including ongoing review of governance and resources.

Members sought assurance by asking the following questions:

Should the need to revisit Temporary Service Changes work, would the team have the capacity to manage this effectively?
This would depend on the Risk appetite overall for the organisation. The team work effectively, given the resources available to adapt to the needs of the health board in order to deliver a programme of engagement. The organisation would need to review how to best manage the totality of risks including financial elements using the resources available.

HT referred to the assessment against the quality standards and noted the Communication team is composed of a range of substantial and temporary appointments with a plan to increase the capacity of the team. The Executive Committee had recently discussed team expansion with a risk to not having a functioning team to lead the communications and engagement work with frontline staff, stakeholders and the public. Further discussions are underway regarding how current capacity is sustained. A paper would be submitted to the Board for consideration to incorporate into the annual plan for the next financial year.

The Committee **DISCUSSED** the report and took **ASSURANCE** from the PTHB Engagement and Communication Team Q2 Impact and Delivery Assurance Report.

5.7 IN-REACH FRAGILITY (D&P/24/086)

EL introduced the report and noted the importance to recognise Powys' strong position, comparable to other health boards across Wales. The position statement is taken from the Integrated Quality and Performance report which lays out the complexities on provision across nine sites in Powys. Powys has a high dependence on commissioned in-reach service provision to achieve performance targets. Access targets cannot be achieved without in-reach provision.

Challenges across in-reach Planned care linked to the wider NHS Planned Care system is ongoing. Work is underway to develop more sustainable services and discussions continue with Commissioned Service providers to explore capacity opportunities and fragility challenges.
KW added that a new AMD had been recruited to within planned care to review pathways and outcomes focusing on Gastroenterology and to review commissioning arrangements from a clinical perspective.
Members sought assurance by asking the following questions:

Are consultants contributing to the In-reach services not attending because of demands in their DGH, or does it reflect the fact that PTHB in-services are generally of lower clinical priority?
NJ confirmed that SLAs are based upon a service and not an individual with the requirement to give notice both sides. A number of 'at risk' areas are present across Endoscopy which are being worked through in collaboration with other health board. This will be kept under close review whilst reviewing service provision.

What is the position regarding Joint appointments between PTHB and the DGH as a possible aid to reducing in-reach 'no shows'?

Joint appointments require strengthening and the health board are in continuous dialogue with other Trusts to look at options to repatriate services with recruitment remaining a significant challenge across larger Organisations. KW stated that the loss of JAG accreditation has no impact upon service delivery.

The Committee welcomed the report which illustrated the complexities across the In-reach service. It was agreed to bring an update report back to Committee on an annual cycle to review the position. It was also agreed that an update report regarding JAG accreditation would be considered to the Patient Experience, Quality and Safety Committee to reflect on the quality elements.

Action: Executive Director of Primary, Community Care and Mental Health./Executive Medical Director

The Committee **RECEIVED** the updated report and took **ASSURANCE** that the organisation has clear understanding of its in-reach provision and associated risks.

5.8 DIGITAL FIRST MONITORING REPORT (D&P/24/087)

CM presented the report and noted that the presentation would be collated into an annual report going forwards to include the challenges faced across Digital and the planned work for the forthcoming year. Key achievements, challenges and forward plan were highlighted across the Digital service.

Members sought assurance by asking the following questions:

For patients within a Powys facility, can assurance be provided that access to connectivity and IT services are made available?

Engagement with the Community Council had taken place to address in-patient connectivity across Powys estates. Significant improvement had been made to transform connectivity with further developments planned across the digital workstream. An update would be provided to members outside of the meeting regarding long standing digital issues related to patient experiences.

Action: Executive Director of Allied Health Professions, Health Sciences and Digital

What is the rationale for the low uptake across virtual consultations for planned care?

Low adoption across technology is evident with a continuous challenge across digital literacy. Powys has dedicated individuals to encourage adoption across a number of teams recognising that Powys remains the only health board to drive this.

What is the UK NHS Federated Data Lakehouse?

The majority of data is dispersed across several inconsistent systems. The benefit of collating data into one central location such as the Data Lakehouse enables Powys to undertake analysis to identify trends and drive real data decisions.

Members recognised the key challenges relating to the Cross Border programme and the National vs Local Programme priorities required further discussion at a Board Development session related to Risk 12 on the Corporate Risk Register. Following consideration, an update would be brought back to the Committee.

Action: Director of Corporate Governance

CM suggested that a position statement on Wi-Fi Connectivity across Powys with a forward look of future planning to include information governance would be brought back to Committee for consideration.

Action: Executive Director of Allied Health Professions, Health Sciences and Digital

The Committee:

- Took **ASSURANCE** that arrangements are in place for continued delivery against the Digital Strategic Framework, and that the pace of the delivery to improve the IT Infrastructure and Data Platform had been significant.
- **CONSIDERED** the updates in relation to the first twelve months of delivery against the Digital Strategic Framework (DSF)
- Took **ASSURANCE** of the actions and workstreams undertaken to improve and upgrade the Digital Services offering as set out in the DSF.
- **NOTED** the key achievements and successful implementation of the Target Operating Model (TOM) and;
- **NOTED** the challenges for the Cross Border programme, national priorities and local priorities, and digital adoption across the organisation.

5.9 COMMITTEE RISK REGISTER (D&P/24/088)

HB presented the report explaining that the Committee Risk Register had been in development and now provides an actioned based Risk Register inclusive of six risks that fell within the Committee's remit, two of the risks would be held in private session given the sensitivity of its content.

The Committee **NOTED** the November 2024 version of the Committee Risk Register and took **ASSURANCE** that it is a complete and a true reflection of the Committee's current high-level risks.

6. ITEMS FOR DISCUSSION

There were no items for discussion.

7. CONSENT AGENDA

7.1 COMMITTEE WORK PROGRAMME (FOR INFORMATION) (D&P/24/089)

The Committee **RECEIVED** the Committee Work Programme for 2024/2025.

8. OTHER MATTERS

8.1 ANY OTHER URGENT BUSINESS (D&P/24/090)

No urgent business was raised.

8.2 ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND/OR OTHER COMMITTEES (D&P/24/091)

As agreed under agenda item 5.7, an update report regarding JAG accreditation would be considered to the Patient Experience, Quality and Safety Committee.

8.3. COMMITTEE REFLECTIONS (D&P/24/092)

The following summary of business and reflections were provided by members:

- Agenda deemed manageable and good variety of reporting
- Quality of reports and appropriate to the committee
- Timing of agenda items worked very well
- Excellent practice covers challenges as needed.
- Appreciate wider focus on Delivery and Performance e.g., Dental and Pharmacy
- Broader participation provided exposure

8.4 DATE OF THE NEXT MEETING (D&P/24/093)

The date of the next meeting is scheduled on 06 February 2025 at 10:00 via Microsoft Teams.
8.5 The following resolution was passed:
'Representatives of the press and other members of the public shall be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.'

Members Present:		
Rhobert Lewis – Chair	RL	Independent Member (General)
Kirsty Williams	KWi	Independent Member (PTHB Vice-Chair)
Cathie Poynton	CP	Trade Union
Steve Elliot	SE	Independent Member (Finance)
In Attendance:		
Pete Hopgood	PH	Deputy Chief Executive and Executive Director of Finance, Capital and Support Services
Elaine Lorton	EL	Executive Director of Primary, Community Care and Mental Health Services
Claire Madsen	CM	Executive Director of Allied Health Professions, Health Sciences and Digital
Nicola Johnson	NJ	Executive Director of Commissioning, Performance and Planning
Hayley Thomas	HT	Chief Executive Officer
Claire Roche	CR	Executive Director of Nursing, Quality, Women and Family Health
Kate Wright	KW	Executive Medical Director
Helen Bushell	HB	Director of Corporate Governance/Board Secretary
Beth Powell (Forum Support)	BP	Corporate Governance Business Officer
Apologies for Absence:		
Ronnie Alexander	RA	Independent Member (Chair)
Mick Giannasi	MG	Independent Member (General)

6.8 CORPORATE RISK REGISTER: CYBER SECURITY AND NATIONAL DIGITAL PROGRAMMES (D&P/IC/24/026)
Rationale for item being held in private: The details of the report and sensitive, confidential and not in the public interest. The Committee **RECEIVED** the following Committee Risks and **NOTED** the updates: • Cyber Security • National Digital Programme
6.9 **MINUTES OF THE PREVIOUS IN-COMMITTEE MEETING (D&P/IC/24/027)**
The Committee **RECEIVED** the item and **APPROVED** the In-Committee Minutes of the meeting held on 22 October 2024 as an accurate and true record.

Meeting Closed at 12:50

Powell,Bethan
03/02/2025 16:55:30

RAG Status:								
At risk	Red - action date passed or revised date needed							
On track	Yellow - action on target to be completed by agreed/revised date							
Completed	Green - action complete							
No longer neede	Blue - action to be removed and/or replaced by new action							
Transferred	Grey - Transferred to another group							

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Delivery and Performance Committee

Meeting Date	Item Reference	Lead	Meeting Item Title	Details of Action	Update on Progress	Original target date	Revised Target Date	RAG status
OPEN ACTIONS FOR REVIEW - NONE								
OPEN ACTIONS - IN PROGRESS BUT NOT YET DUE (06 FEBRUARY 2025)								
05-Dec-24	D&P/24/086	Executive Director of Primary, Community Care and Mental Health.	In-reach Fragiity	It was agreed to bring an update report back to Committee on an annual cycle to review the position.	**06.02.25 update** - item scheduled for December 2025 - to consider reports by exception in May, Sept if there are any significant changes/financial challenges impacting on in reach capacity.	May-25		On track
ACTIONS RECOMMENDED FOR CLOSURE (06 FEBRUARY 2025)								
05-Dec-24	D&P/24/086a	Executive Medical Director	In-reach Fragility	It was agreed that an update report regarding JAG accreditation would be considered to the Patient Experience, Quality and Safety Committee to reflect on quality elements.	Transferred to PEQS Committee. The PEQS Committee would focus on the patient experience aspect and quality of service to provide further assurance on what is being done to regain the accreditation. Schedule for July 2025.			Transferred
05-Dec-24	D&P/24/083c	Executive Director of Primary, Community Care and Mental Health.	Primary Care: GDS	It was agreed that a report would be considered at the Patient Experience, Quality and Safety Committee in the near future to fully understand how quality is measured from a general and community dental perspective.	Transferred to PEQS Committee **Update 16.01.25** - A paper can offer assurance to PEQS on quality and will include reference to the following examples of assurance and evidence •NHSBSA patient satisfaction surveys •Clinical Record Card Audits, carried out by health board and NHSBSA clinical policy advisors •HIW visit reports •Self-audit for CDS and GDS •Provider assurance reports •CDS internal patient satisfaction surveys •Annual QAS, completed by CDS and GDS hosted by PHW. •DATIX for CDS •Concerns for GDS •Mandatory training requirements for dental team Both CDS and GDS monitoring have Q&S has a standing agenda item.			Transferred
05-Dec-24	D&P/24/064	Executive Director of Primary, Community Care and Mental Health.	GMS access	Powys are awaiting guidance from Welsh Government on the actions to be undertaken regarding access. Feedback would be provided to the committee at the next meeting in February 2025 with a brief discussion with the Committee Chair prior to this meeting.	**16.01.25 update** - Under the Strategic Programme for Primary care, a national Task & Finish Group has been established looking at the challenges of access to GMS service. The Group is under the under the leadership of Paul Mears (Lead CEO for Primary Care and CEO of CTMUHB) to review a range of access issues; looking at what the information on access is saying across Wales , the differing public perceptions of access , the communication messages that are required; and to consider what some of the solutions to access challenges might be. This work is linking in with the Wales Cluster Leads Group to look at the challenges being faced and what the solutions could be working at a National , Health Board , Cluster & Practice level. A Wales Cluster Leads workshop has been arranged for 21/01/25. HBs will continue to be updated on the outputs and progress developing from this Group	Feb-25		Completed
05-Dec-24	D&P/24/079	Executive Director of Commissioning, Planning and Performance	Organisational Status Enhanced Monitoring	Plans are ongoing for WG colleagues to attend a Board Development session to discuss the escalation status given a different level of scrutiny. Following discussions, feedback would be provided to the committee on how the organisation plans to respond to the escalation status going forwards.	**03.02.25 update** - WG colleagues joined the Board dveelopment session in December, an update will be provided within the meeting agenda.	Feb-25		Completed
05-Dec-24	D&P/24/083	Executive Director of Primary, Community Care and Mental Health.	Primary Care: GDS	To confirm the last 3 years of data trends which specify the number of patients waiting for routine dental care to date.	**27.01.25 update:** 2021/22: 1,188 patients (waiting list only started in Sep 2021, so not a full financial year) 2022/23: 4,651 patients 2023/24: 4,502 patients			Completed
05-Dec-24	D&P/24/083a	Executive Director of Primary, Community Care and Mental Health.	Primary Care: GDS	To review scope to support Service familys access to dental care whilst temporarily living in Powys.	**16.01.25 update** - The PTHB Dental Help line number can offer advice and allocate to GDS/CDS if urgent dental care is required. Patients requiring routine access and for appropriate periods of stay can be prioritised for an assessment in CDS/GDS where capacity allows. Access availability across the county to accommodate this			Completed

05-Dec-24	D&P/24/083b	Executive Director of Primary, Community Care and Mental Health.	Primary Care: GDS	To review the Children and Young People and Adults stats which show only 49% of children receive dental treatment which does not represent a realistic reflection, this would be reviewed by the DPCCMH and reported back to the committee for clarity.	**16.01.25 update -** No children wait on the DAP (waiting list) for more than a few weeks as they are prioritised and allocated GDS/CDS appointments. The DAP is only a measurement of children who wish to access an NHS dental service. The employment of the Dental Therapist in the CDS based in North Powys sees children under a direct access model. Additional Dental Therapist are employed in Glan Irfon to support access. In addition we are currently attempting to recruit 0.6 WTE Dental Therapist in South Powys to increase child access. There is a pathway in place for 'Looked after Children' via the CDS. In addition the 'Design 2 Smile' service will identify children who have active tooth decay and offer an appointment in the CDS if they do not have access to a dental practice. Using population data from the 2021 census – the population of Powys was 133,200 of which 23,468 were under 18. Using this population data and the December figures from eDen there was: -11,577 children that received NHS Dental care over a 12-month period which is 49% of the population.			Completed
05-Dec-24	D&P/24/087	Executive Director of Allied Health Professions, Health Sciences and Digital	Digital First Monitoring	An update would be provided to members outside of the meeting regarding long standing digital issues related to patient experiences.	**23.01.2025 update** - This information from patients has not been recorded in a way that we are able to report robustly, in the main it relates to poor guest wifi for inpatients and as such we are adding a question relating to Digital Access on the Civica patient experience platform to enable better collection of digital issues.			Completed
05-Dec-24	D&P/24/087b	Executive Director of Allied Health Professions, Health Sciences and Digital	Digital First Monitoring	A position statement of Connectivity across Powys with a forward look of future planning to include information governance would be brought back to Committee for consideration.	**23.01.2025 update -** Connectivity across Powys has significantly improved, for example the corporate wifi, has been improved on all of the HB sites, with additional capacity implemented. Guest Wifi Connectivity will have improved by switching the provider from Powys County Council to BT by the end of this financial year.			Completed
05-Dec-24	D&P/24/065	Executive Director of Primary, Community Care and Mental Health.	Clusters achievements review	It was agreed that an annual update would be presented to Committee members to look at the system of Clusters.	**06.12.2024 update -** Added to the Committee work programme for June 2025 and on an annual cycle. Action recommended for closure on that basis.	Jun-25		Completed
05-Dec-24	D&P/24/087a	Director of Corporate Governance	Digital First Monitoring	Recognised the key challenges relating to the Cross Border programme and the National vs Local Programme priorities required further discussion at a Board Development session which relates to Risk 12 within the CRR regarding Digital Programmes. Following consideration, an update would be brought back to the Committee.	06.02.25 update - item scheduled into Board Development programme for March 2025. Recommended for closure on that basis.			Completed

Powys THB Finance Department
Financial Performance Report
Delivery and Performance Committee

Period 09 (December 2024)
FY 2024/25

Date Meeting: 06 February 2025

GIG CYMRU NHS WALES
Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Introduction

Subject:	**FINANCIAL PERFORMANCE REPORT FOR MONTH 09 OF FY 2024/25**
Approved & Presented by:	Pete Hopgood, Director of Finance
Prepared by:	Hywel Pullen, Deputy Director of Finance
Other Committees and meetings considered at:	Executive Committee

PURPOSE:

This paper provides an update on the December 2024 (Month 09) Financial Position, including progress with savings delivery.

RECOMMENDATION:

The Delivery and Performance Committee is asked to:

- **RECEIVE** the financial report and take **ASSURANCE** that the organisation has effective financial monitoring and reporting mechanisms in place.

Powell Bethan
03/02/2025 16:55:30

THE PAPER IS ALIGNED TO THE DELIVERY OF THE FOLLOWING STRATEGIC OBJECTIVE(S) AND HEALTH AND CARE STANDARD(S):

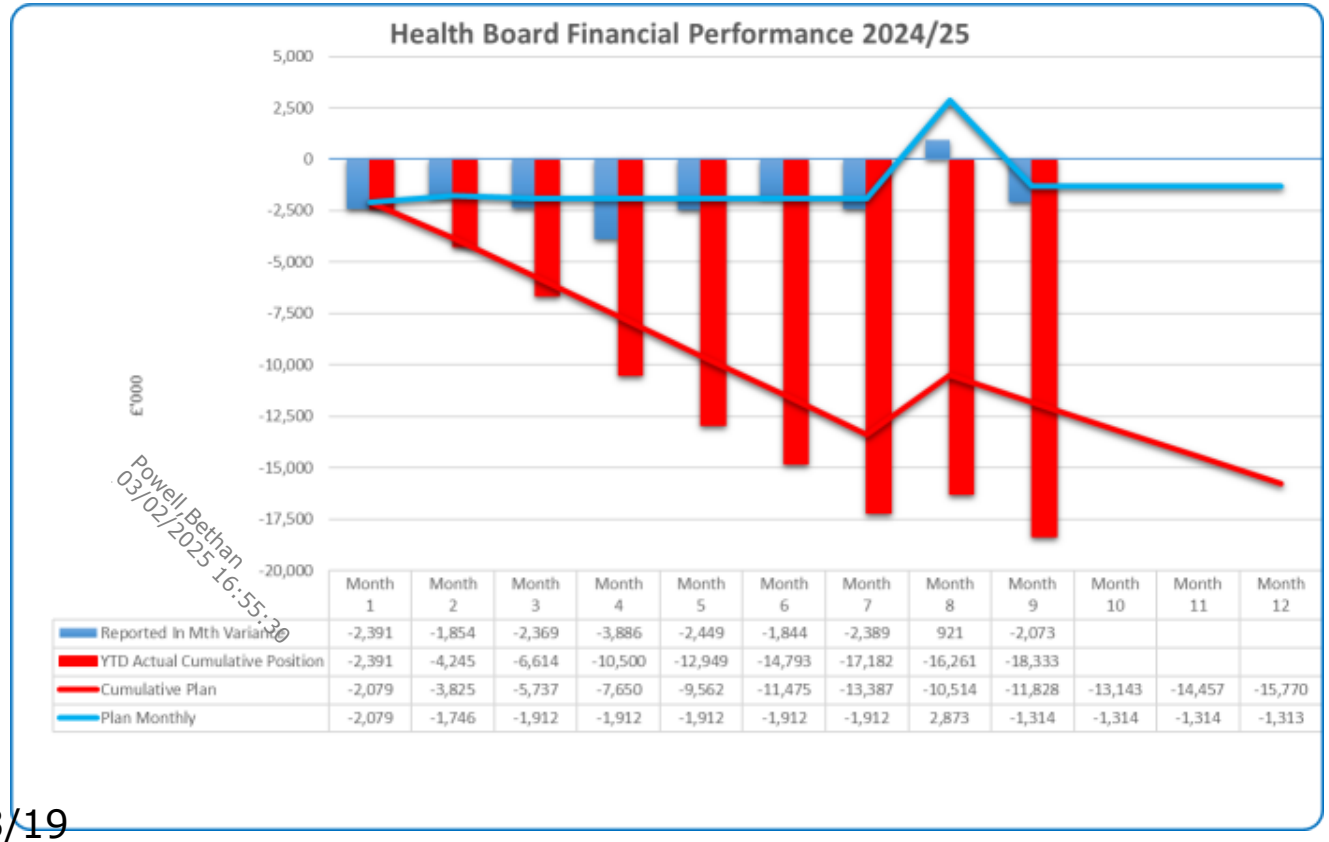
Strategic Objectives:	• Focus on Wellbeing	✖
	• Provide Early Help and Support	✖
	• Tackle the Big Four	✖
	• Enable Joined up Care	✖
	• Develop Workforce Futures	✖
	• Promote Innovative Environments	✖
	• Put Digital First	✖
	• Transforming in Partnership	✓
Health and Care Standards:	• Staying Healthy	✖
	• Safe Care	✖
	• Effective Care	✖
	• Dignified Care	✖
	• Timely Care	✖
	• Individual Care	✖
	• Staff and Resources	✓
	• Governance, Leadership & Accountability	✖

Approval/Ratification/Decision	Discussion	Information
✓	✓	

Summary Health Board Position 2024/25

Revenue			
Financial KPIs : To ensure that net operating costs do not exceed the revenue resource limit set by WG	**Plan £'000**	**Actual £'000**	**Trend**
Reported in-month financial position – (deficit)/surplus	-1,314	-2,073	↑
Reported Year To Date financial position – (deficit)/surplus	-11,828	-18,333	↑
Year end – (deficit)/surplus	-15,770	-15,770	→

Capital		
	Value £'000	**Trend**
Capital Resource Limit	13,138	↑
Reported Year to Date expenditure	2,599	→
Reported year end – (deficit)/surplus – Forecast	0	→



	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Reported In Mth Variance	-2,391	-1,854	-2,369	-3,886	-2,449	-1,844	-2,389	921	-2,073			
YTD Actual Cumulative Position	-2,391	-4,245	-6,614	-10,500	-12,949	-14,793	-17,182	-16,261	-18,333			
Cumulative Plan	-2,079	-3,825	-5,737	-7,650	-9,562	-11,475	-13,387	-10,514	-11,828	-13,143	-14,457	-15,770
Plan Monthly	-2,079	-1,746	-1,912	-1,912	-1,912	-1,912	-1,912	2,873	-1,314	-1,314	-1,314	-1,313

Following notification of additional WG funding allocations of £7.178m in Month 8, the Financial Plan for 2024/25 has been revised from a £22.948m deficit to a deficit £15.770m.

At month 9, there is a £18.333m overspend against the revised planned year to date deficit of £11.828m giving the Health Board an operational overspend of £6.504m.

The year end forecast remains in line with the adjusted Plan at £15.770m, but given the current overspend surpasses this figure, significant remedial actions of over £9m, as discussed by the Board, would be required to achieve the Plan.

The capital resource limit for 2024/25 is £13.138m. To date £2.599m has been spent – £1.362m in month 9. The low level of capital expenditure raises a concern but the work in progress, plans and action are in place to ensure that this is utilised in full. Robust project management arrangements are in place to maximise delivery.

DAY FIVE – summary report

- Commissioning is £6.0m YTD overspent at M09, mainly due to increased Elective and Emergency activity at providers and increased community bed usage.
- Agency expenditure of £0.4m in the month, which is lowest it has been all year and lower than any point in the prior year.
- CHC is overspent by £2.1m YTD in month 9. There are 343 packages of care, a net increase of 12 clients this month.
- Pressures above have been partly offset due to reduced expenditure on prescribing and dental services.

Revenue Variance Position 2024/25

Overall Summary of Variances £'000s

Table B Categories	Budget YTD	Actual YTD	Operational Variance YTD
01 - Revenue Resource Limit	(321,427)	(321,427)	0
02 - Capital Donations	(97)	(97)	0
03 - Other Income	(7,731)	(8,482)	(751)
Total Income	**(329,255)**	**(330,006)**	**(751)**
05 - Primary Care - (excluding Drugs)	34,795	33,821	(974)
06 - Primary care - Drugs & Appliances	28,656	26,718	(1,938)
07 - Provided services -Pay	85,227	87,107	1,880
08 - Provided Services - Non Pay	19,667	19,174	(493)
09 - Secondary care - Drugs	1,062	1,020	(42)
10 - Healthcare Services - Other NHS Bodies	132,533	138,621	6,088
12 - Continuing Care and FNC	24,093	26,190	2,096
13 - Other Private & Voluntary Sector	3,462	4,101	639
14 - Joint Financing & Other	7,604	7,604	(0)
15 - DEL Depreciation etc	3,874	3,874	0
16 - AME Depreciation etc	111	111	0
18 - Profit/Loss Disposal of Assets	0	0	0
Total Costs	**341,084**	**348,339**	**7,255**
Reported Position	**11,829**	**18,333**	**6,504**

At Month 09, there is a £18.333m overspend against the readvised planned deficit of £11.829m giving the Health Board a year-to-date operational overspend of £6.504m.

The most significant adverse variances are on:

- Commissioning of Healthcare Services from other NHS Bodies is £6.088m overspent at M09.
  - This is predominantly caused by issues in the health and social care system manifesting in increased costs in the acute and community sector and increased elective activity.

- Continuing Care and FNC at £2.096m. The number of CHC packages has increased by 12 from 331 in November to 343 in December.

- Pay budgets at £1.880m - driven by the use of agency, from both on and off contract suppliers running at a high rate.

The pressures above have been partly offset due to reduced expenditure on Prescribing, Dental and other non-pay expenditure.

Health Board Provider Services

We are focused on this because:
This page gives a directorate level view of PTHB's corporate and provider services. There are significant budget variances to be understood and managed.

Subset of Table B Categories and Directorate View Variances

Subset of Table B Categories	WTE Bud	WTE Act	WTE Var	Avg WTE	Budget (£'000)	Actual (£'000)	Variance (£'000)
03 - Other Income	0	0	0	0	(7,731)	(8,482)	**(£751)**
07 - Provided services -Pay	2,320	2,098	(222)	2,107	85,227	87,107	**£1,880**
08 - Provided Services - Non Pay	0	0	0	0	19,667	19,174	**(£493)**
Grand Total	**2,320**	**2,098**	**(222)**	**2,108**	**£97,163**	**£97,799**	**£636**
Directorate View							
Corporate and other Sevices	508	464	(44)	481	29,197	26,417	**(£2,780)**
A01 - Assistant Director Community Services	995	910	(85)	904	35,887	34,951	**(£936)**
A02 - Assistant Director MH/LD	502	411	(91)	410	19,105	22,978	**£3,873**
A04 - Assistant Director Women and Children	165	155	(10)	158	5,518	5,681	**£162**
N04 - Assistant Director Support Services	150	158	8	155	7,455	7,772	**£317**
Grand Total	**2,320**	**2,098**	**(222)**	**2,108**	**£97,163**	**£97,799**	**£636**

Note: The above table only relates to the directly provided services for the directorates shown. These directorates are also accountable for other areas, such as CHC, Commissioning, Private Providers and Voluntary Sector, which is not included in the above.

Explanation of Performance

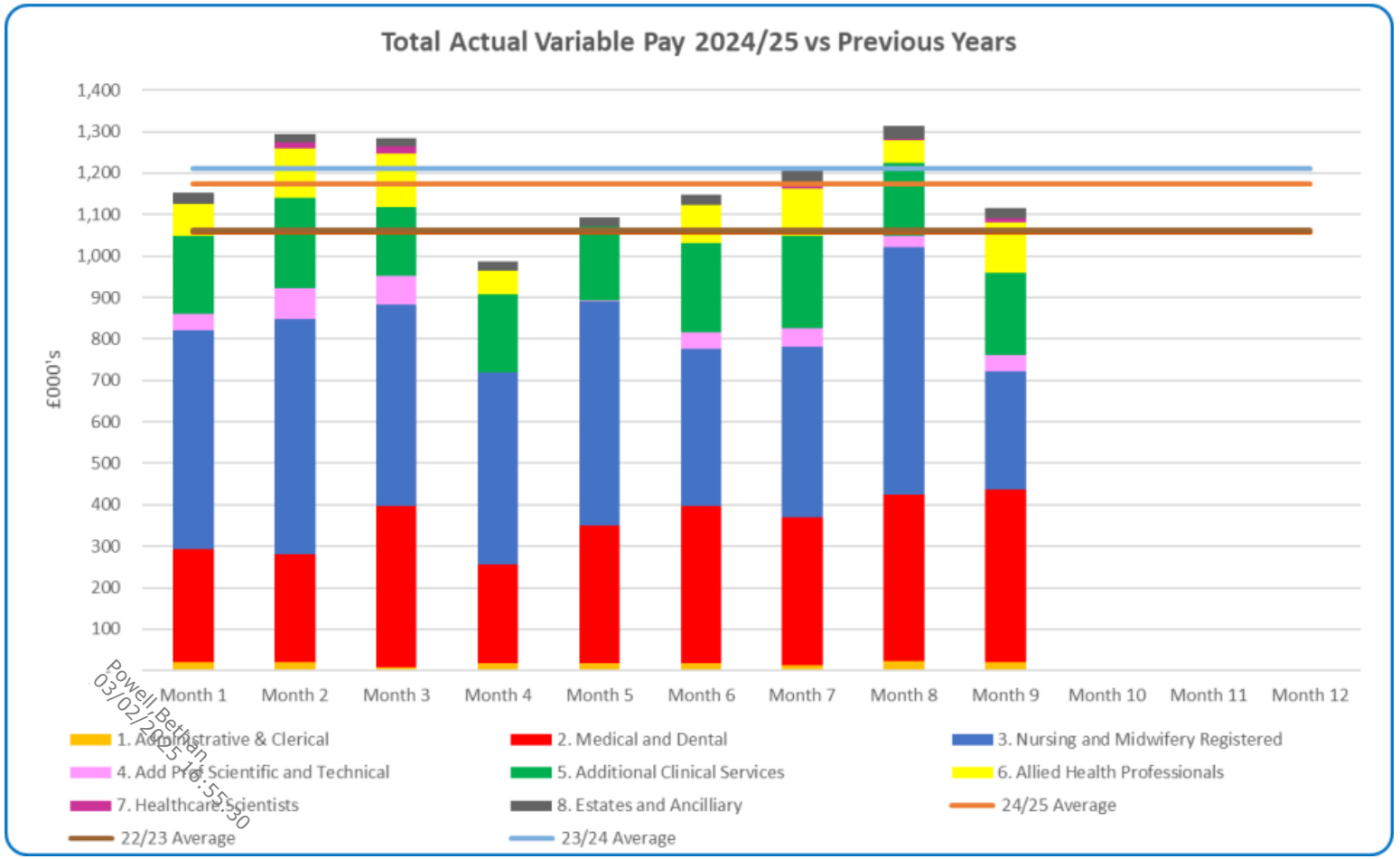
- The Month 09 YTD position is showing an overspend of £0.636m over these categories
- Corporate and Community services are underspent, whilst other directorates are over-spent.
- The service with the largest overspend is Mental Health. This is predominately due to increased agency and locum expenditure and the underachievement of savings.
- Vacancies are running at 18% (91 WTE) for MH Services and 9% (85 WTE) for Community Services.
- The following page provides more detail on agency expenditure and the actions being taken to address the high usage.

Risks

- Increased workforce gaps resulting in greater requirement for temporary workforce, and associated premium spend.

Health Board Agency Spend

We are focused on this because:
Tackling our high agency spend levels (volume and price) is key to successfully mitigating financial risk and achieving the financial plan. Agency spend is far too high and is adversely impacting upon our use of resources (and wider outcomes).



What the charts tells us: Agency usage is at an unsustainable level and poses a significant risk to the achievement of the financial plan.

Performance and Actions

- Pay budgets are overspent by £1.880m against the year-to-date plan, due to the high level of vacancies.
- The chart opposite demonstrates in December variable pay is lower than prior months. It is broken down by staff type.
- Powys continues to be an outlier within NHS Wales as agency spend was on average 9.5% of total pay in Month 8, against the Wales average of 2.8%.
- The HB's Variable Pay Reduction group is implementing its action plan. There are improvements on the wards in CSG, but high expenditure run rates remain in non-ward services and Mental Health.

Risks

- Level of agency (% of pay).
- Increased workforce gaps resulting in greater requirement for temporary workforce.
- Supply and demand price pressures leading to use of off-contract agencies.

Commissioning and Contracting

We are focused on this because:
Commissioning of secondary and tertiary healthcare services is circa 40% of all expenditure and has been growing steadily. It is a core component of the Health Board's Strategy facilitated through the transformation programme.

Status Update
Welsh LTAs for 2024/25 were agreed by the deadline of 30 June and the contract proposals from English providers are currently being negotiated. The variances against budget are based on the seven months of activity information that has been received to date, with the exception of Shrewsbury and Telford Hospitals (SaTH), which is unable to report its activity. Providers ability to deliver both core and recovery activity is variable and is monitored closely.

NHS Commissioning Variance to Date 2024/25

Commissioning	Budget to Date £000	Actual to Date £000	Variance to Date £000
Welsh Providers	33,583	34,530	947
English Providers	53,854	58,325	4,470
JCC	41,043	41,715	673
Other NHS Providers	3,388	3,358	(30)
Mental Health (LTAs Only)	665	693	28
Total	**132,533**	**138,621**	**6,088**

Risks

- Capacity and performance of Adult Social Care services
- Providers exceed their RTT recovery targets.
- Winter pressures and capacity of the system generally to treat patients and thus avoid secondary care admissions.
- Delivery of saving plans.

Performance

Expenditure is affected by system delays for patients (see next page) and the pace of recovery of elective activity by provider organisations. The marked deterioration this month is due to assuming a lower level of funding in respect of the pay award in the English NHS.

Notable pressures:

- Cwm Taf Morgannwg Health Board is reporting a 19% increase in emergency activity (at Prince Charles Hospital in Merthyr Tydfil).
- Wye Valley Trust - significant increase in community hospital attendances; length of stay in hospital and emergency and elective admissions.
- JCC - the ICP approved on an All Wales consensual basis above financial plan allocation with assumption that further savings would be achieved.
- Private Providers – due to Velindre Ward, Bronllys, not operating at full capacity earlier in the year. (YTD overspend of £1.2m is in addition to the variance in the table opposite)

Secondary Care and Community hospital delays

We are focused on this because:
The delay in discharges from community and district general hospitals due to capacity and performance challenges within Adult Social Care services is causing an increasing pressure on the Health Board.

- The table opposite includes both health and adult social care (ASC) related delayed discharges. It distinguishes between Powys community hospitals and the two English health systems (Shropshire and Herefordshire).
- The District General Hospital (DGH) delays includes information from our neighbouring hospitals around the perimeter of Powys.
- The table shows that of delayed discharges to date:
  - 4,867 days within Powys community hospitals related to Health processes and 12,279 days as a result of Social Care. Associated costs of £2.9m and £7.2m, respectively.
  - 4,109 days within English community and district general hospitals (DGHs) related to Health processes and 9,557 days as a result of Social Care. Associated costs of £1.3m and £3.1m, respectively.

Please note the days are costed at full cost to PtHB of £590 in Powys, £432 for a community hospital in England and £301 for an excess bed day in a DGH.

Gross Cost of Delays	Health YTD		Social Care YTD	
	Days	£m	Days	£m
PTHB Provider Delays	1,408	£0.8	6,814	£4.0
PTHB Provider Assessment Delays	3,459	£2.0	5,465	£3.2
Subtotal PTHB Provider	**4,867**	**£2.9**	**12,279**	**£7.2**
Shropshire Community Bed Delays	30	£0.0	465	£0.2
WVT Community Bed Delays	131	£0.1	1,245	£0.5
DGH Bed Delays	3,948	£1.2	7,847	£2.4
Subtotal English & Welsh Providers	**4,109**	**£1.3**	**9,557**	**£3.1**
Total Opportunity Cost (at full cost)	**8,976**	**£4.1**	**21,836**	**£10.4**

Performance and action:
This is a challenging situation with increased risks for patients, the effective operation of services and the financial performance. The Heath Board works in partnership with the Council to address the underlying issues.

Prescribing

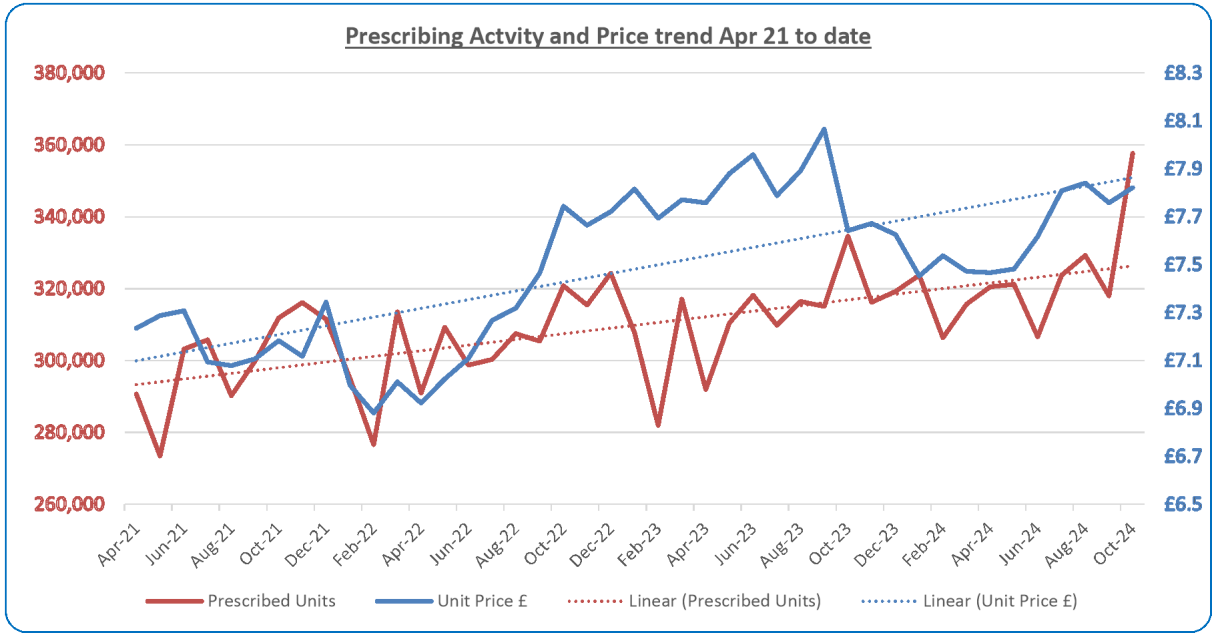
We are focused on this because:

The costs of prescribing have risen significantly from April 2022. This was driven by both price inflation and increased prescribing activity. Whilst prescribing costs rose during FY23-24, the final outturn reduced significantly from earlier forecasts in line with reduced prices on certain drugs, and other successful savings initiatives. This trend has continued into FY24-25 which is driving a significant saving against budget in the M8 forecast.

Status Update

A forecast underspend of -£1.8m on 2024/25 budget of £31.1m (incl £1.1m saving target). Prescribing costs are reported 2 months in arrears. This is a £200k deterioration from the M8 forecast.

- YTD costs, M1-M7, are broadly in line with M1-M7 in 2023-24, 1.5% increase.
- Unit price decrease year on year of -0.5% in FY24-25, driven by NCSO/price concessions. Unit costs are expected to continue at a lower rate until Q3 when the full year effect of the Apixaban cost reduction is fully included.
- Prescribing activity year on year increase of 3.7%.



Prescribing cost increases	FY20-21	FY21-22	FY22-23	FY23-24	FY24-25 (f'cast)
	£k	£k	£k	£k	£k
Prescribing Budget	22,320	23,182	24,694	28,959	31,161
Prescribing Annual costs	25,953	25,610	27,469	29,195	29,324
Yr on Yr % increase/decrease	4.4%	-1.3%	7.3%	6.3%	0.4%
Yr on Yr increase £ Total	**1,086**	**-344**	**1,859**	**1,727**	**128**
Yr on Yr increase £ Growth	-109	475	655	747	971
Yr on Yr increase £ Inflation	1,196	-819	1,204	980	-843

Risks & Challenges

- High proportion of dispensing practices: (38% of patients receive medicines from a dispensing practice; 79% of patients are registered with a dispensing practice)
- Access and control to prescribing data, audit participation, other services driving prescribing activity.
- Responsibilities for prescribing vs accountability for the prescribing budget.

Medicines Management savings performance and actions

- Schemes forecast to deliver £2.211m savings, an increase over target of £1.111m (price reductions for DOACs).
- Guidance and support is given to Primary Care including, decision support software, monthly KPI reporting, practice visits, shared formulary and presc. guidelines, audit & shared care agreements.
- Active involvement in NHS Wales pharmacy and finance fora, including the Value and Sustainability Board workstream.

Continuing Healthcare Forecast 2024/25

We are focused on this because:
Commissioning of complex healthcare packages is an area of significant expenditure growth (price inflation and number of packages).
Maintaining strong and transparent governance over CHC processes is crucial for financial sustainability and relationships with our partners.

Area	19/20 Year end Position £'000	20/21 Year end Position £'000	21/22 Year end Position £'000	22/23 Year end Position £'000	23/24 Year end Position £'000	24/25 Budget £'000	24/25 Forecast £'000	Growth 2023/24 to 2024/25 Forecast £'000	Growth 2023/24 to 2024/25 Forecast %
Children	£267	£151	£157	£296	£310	£331	£566	£256	82.6%
Learning Disabilities	£957	£1,568	£1,639	£2,461	£3,549	£3,836	£4,476	£927	26.1%
Mental Health	£7,344	£7,801	£10,611	£13,949	£16,201	£17,324	£19,597	£3,397	21.0%
Mid Locality	£981	£925	£1,635	£1,882	£2,123	£2,297	£2,628	£504	23.8%
North Locality	£1,365	£1,537	£2,098	£2,646	£3,475	£3,817	£4,188	£713	20.5%
South Locality	£1,495	£1,958	£1,853	£1,904	£1,955	£2,030	£1,186	(£769)	-39.3%
Grand Total	**£12,410**	**£13,941**	**£17,994**	**£23,138**	**£27,613**	**£29,636**	**£32,642**	**£5,029**	**18.2%**
Number of active clients	**230**	**243**	**285**	**295**	**327**	**315**	**343**	**16**	**4.9%**
D2RA				**£696**	**£201**	**£0**	**£8**	(£194)	-96.2%
FNC	**£2,218**	**£2,095**	**£1,960**	**£2,131**	**£2,279**	**£2,489**	**£2,649**	**£370**	**16.2%**
Total	**£14,628**	**£16,035**	**£19,954**	**£25,966**	**£30,093**	**£32,124**	**£35,298**	**£5,204**	**17.3%**

Performance and Action
The 2024/25 financial plan had provision for CHC inflation and assumed that the number of packages would remain consistent with the position in the autumn of 2024.

As at month 09, there is an overspend of £2.096m on year-to-date budget of £24.093m against Continuing Care and FNC. The number of CHC packages has increased by 12 from 331 in November to 343 in December.

Across Wales, at Month 8, the forecast is for an 9.9% increase in costs in 2024/25 compared to 2023/24.

The CHC team is working with local care homes to simplify the fee rates and promptly review placements. It is responding to the opportunities identified by the national V&S Board.

What the table tells us

The table shows the significant growth in CHC costs across all categories (mental health, learning disability, children and frail adults). If this continues unabated it poses a significant risk to the achievement of the financial plan and medium-term sustainability.

Risks

The HB has seen a significant increase in the complexity and number of patients requiring CHC, there is a risk the growth continues in 2024/25 above that planned for and beyond the levels that can be mitigated.

There is a pressure on the weekly fees charged for packages of care.

Health Board 2024/25 Savings Programme

We are focused on this because:
Delivering savings is key to successfully mitigating financial risk and achieving the financial plan. Maximising recurrent savings is key to our financial sustainability and tackling our underlying deficit into the medium term.

Forecast Performance of Saving Schemes by Programme

	(£ '000s)						
	In-year 2024/25					Recurrent for future years	
Targeted Area	24/25 Recurrent Savings Target	Green (forecast)	Amber (forecast)	Green + Amber (forecast)	Forecast vs Target	Forecast FYE	FYE vrs Recurrent Target
2% Saving	**970**	2,509	11	2,520	1,550	901	-69
Continuing Health Care (CHC)	**430**	430	0	430	0	430	0
Commissioning	**1,650**	732	60	792	-858	824	-826
Community	**1,180**	1,283	0	1,283	103	1,187	7
Covid	**1,250**	1,324	0	1,324	74	730	-520
Medicine Management	**1,100**	2,211	0	2,211	1,111	2,211	1,111
Mental Health	**1,320**	646	75	721	-599	75	-1,245
Commissioning - Delayed Transfer of Care Repatriation	**750**	434	0	434	-316	434	-316
Community - Discharge Support	**1,250**	176	0	176	-1,074	0	-1,250
Total	**9,900**	9,746	146	9,892	-8	6,792	-3,108

What the table tells us

Focus is on converting opportunities into deliverable schemes. Particularly recurrent schemes to impact upon the underlying financial deficit.

Risks

Timescales and capacity of teams to deliver the schemes.

WG Value & Sustainability Board

V&S Board Category	24/25 Recurrent Savings Target £'000
CHC	430
Medicines Management	1,100
Other - Commissioning	2,400
Other - Primary Care	0
Pathway	0
Procurement & Non-pay	3,470
Workforce	2,500
Grand Total	9,900

Performance and Actions

- As shown in the table £9.892m savings have been forecast in 2024/25, giving an under achievement of £0.008m against the £9.9m target.
- The recurrent impact of saving schemes at £6.792m, is a shortfall of £3.108m against the £9.900m recurrent target. This has an adverse impact on the Health Board's underlying deficit.

Note: RAG rating is per WG's guidance in WHC (2023) 012: Welsh Health Circular 2023 012 (English).pdf

Risks and Opportunities

We are focused on this because:
The revised £15.770 deficit budget is ambitious and there is an increased risk associated with it. It is based on key underlying assumptions and a range of risks and opportunities the Health Board is exposed to as it seeks to achieve the revised £15.770m target deficit total.

Table reported to Welsh Government

Risk	£ '000	Likelihood
Continuing Healthcare	-500	Medium
Prescribing	-950	Medium
Other Contract Performance	-1,000	High
Dental PCR Income	-200	High
Other Non Pay	-400	Medium
Achievement of Further Mitigations	-9,444	High
Band 2 to 3 HCSW employment dispute	Not Quantified	Medium
Total	**-12,494**	
Opportunity		
Commissioning	500	Low
Continuing Healthcare - Winter Impact	500	Medium
Core	1,000	Medium
Prescribing - Drug Price Reduction	500	Medium
Total	**2,500**	

Risks

- Given the level of growth seen over recent years there is a risk that CHC cases will exceed that assumed in the Plan and Forecast.
- There has been significant volatility in prescribing growth and inflation over recent years together with dispensing fees, and there is a risk that should these continue into 2024/25 that this may present a risk of circa £0.950m.
- There is a potential risk of circa £1.000m for the Health Board relating to the level of activity undertaken by our providers, compare to Forecast.
- **Achievement of Further Mitigations – There is a potential risk of circa £9.444m around remedial actions that are needed to manage the Health Board's financial performance.**

We are focused on this because:
Currently, the financial forecast for 2024/25 is to achieve the readvised financial plan of £15.8 deficit budget. However, as set out in the previous slide the balance of risks far outweigh opportunities. The Board would need to authorise a series of urgent and highly impactful remedial actions to achieve the Plan.

1. In March 2024, when the financial plan for a £25m deficit was approved, it was acknowledged that it was challenging, but reflected the ambitions of the Board and was based upon clear, robust assumptions.

2. In May 2024, the financial plan was improved to £23m based upon the identification of two specific further actions to seek funding for the Ready To Go Home units from the RIF and to prioritise the repatriation of patients in Herefordshire and Shropshire.

3. In November 2024, the financial plan was improved to £15.8m following the notification of additional funding allocations of £7.2m from Welsh Government to be applied to the planned deficit.

4. Based upon the financial position at Month 9, it is forecast that significant remedial actions with an impact of £9.4m are necessary to achieve the financial plan.

5. The underlying deficit of the organisation has been re-evaluated. As some of the existing off-setting savings and options for further mitigations being considered by the Board are non-recurrent in nature, the underlying deficit is assessed at £27.6m. This will be kept under review.

Summary & Key Messages

1. At month 09, PTHB is reporting a £18.333m deficit. This comprises the profiled revised planned deficit £11.829m, with an **operational overspend of £6.504m**.
   - Actions are progressing to deliver the £9.9m savings target. Further work is required to achieve it recurrently.
   - Commissioning of healthcare is overspending, due to increased emergency and elective activity and associated costs.
   - The key operational pressures needing to be addressed are discharging patients from hospitals and agency expenditure, especially within mental health services.
   - CHC costs are much greater than budgeted for, due to greater number of packages of care and the case mix.

2. Following the additional allocations of £7.178m in Month 8, there is a revised plan for 2024/25, which aims to achieve a deficit £15.770m. Achieving this forecast will be increasingly challenging to the Health Board, given the expenditure run rates it is experiencing and the level of risks it is subject to. **To achieve the Plan, the Board needs to authorise a series of urgent and highly impactful remedial actions.**

3. The Health Board's planned underlying position has been revised taking into account the £7.2m allocation (£5m conditionally recurrent) and the recurrent nature of specific cost pressures. These need to be managed in 2024/25. Some of the existing off-setting savings and options for further mitigations being considered by the Board are non-recurrent in nature. The underlying deficit is assessed at £27.6m.

4. Other financial matters:
   - The Health Board has a £13.138m capital allocation, which it will manage within. As highlighted on Page 1, capital expenditure in the first 9 months is relatively low with work in progress, plans and action in place to utilise the allocation in full. This will be closely monitored.
   - Due to the £15.8m revised forecast financial deficit, the THB will require Strategic Cash in February 2025 to meet its obligations to suppliers and staff. An Accountable Officer letter has been sent formally requesting this, any variance against the plan would be subject to further discussion and agreement.
   - The Health Board is not currently achieving the target of paying 95% of non-NHS invoices within 30 days. This is due to delays in the process for approving agency invoices. By number, the YTD performance is 93.5%.

Powys THB Finance Department
Financial Performance Report – Appendices

Monitoring Return Reported

Embedded below are extracts from the Monthly Monitoring Return submitted to Welsh Government on 14th January 2025.

MMR Narrative

Microsoft Edge
PDF Document

MMR Tables

Microsoft Excel
Worksheet

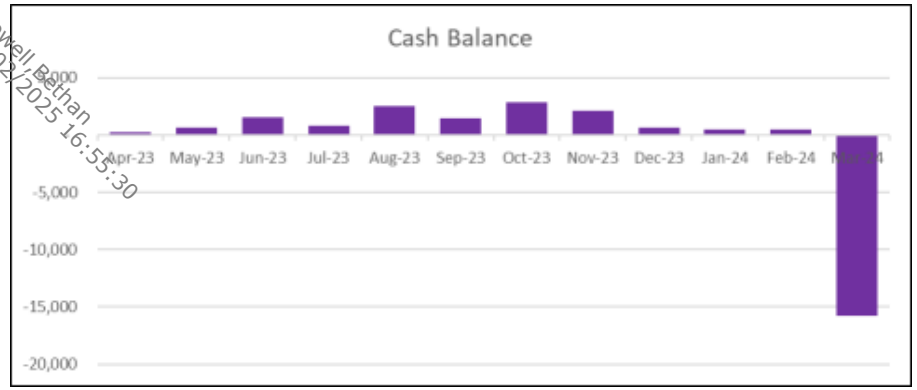
Capital 2024/25

Scheme	Capital Resource Limit	Annual Planned Expenditure	Expenditure to 31st December 2024
WG CRL FUNDING	**£M**	**£M**	**£M**
Discretionary Capital	0.978	0.978	0.568
EFAB Infrastructure	0.304	0.304	0.041
EFAB Fire	1.208	1.208	0.200
Replacement Roofing, Bronllys Hospital	0.216	0.216	0.127
Diagnostic Equipment 2024-25	1.700	1.700	0.160
Backlog Maintenance 2024-25 - Llandrindod Wells	3.000	3.000	0.509
DPIF - RISP	0.214	0.214	0.137
DPIF - Electronic Prescribing and Medicines Administration (EPMA) Implementation	0.198	0.198	0.107
Decarbonisation Programme	3.624	3.624	0.749
Year End Funding - October 2024	1.028	1.028	0.001
Diagnostic and Medical Equipment 2024-25	0.100	0.100	0.000
Digital Eqipment - December 2024-25	0.391	0.391	0.000
IFRS16 Leases - Tranche 1	0.177	0.177	0.000
Donated assets - Purchase	0.130	0.130	0.000
Donated assets (receipt)	-0.130	-0.130	0.000
TOTAL APPROVED FUNDING	**13.138**	**13.138**	**2.599**

Cash Flow 2024/25

Appendix 3

	Mth 1 £'000	Mth 2 £'000	Mth 3 £'000	Mth 4 £'000	Mth 5 £'000	Mth 6 £'000	Mth 7 £'000	Mth 8 £'000	Mth 9 £'000	Mth 10 £'000	Mth 11 £'000	Mth 12 £'000
OPENING CASH BALANCE	**215**	**201**	**663**	**1,577**	**783**	**2,559**	**1,465**	**2,845**	**2,092**	**682**	**500**	**500**
Receipts												
WG Revenue Funding - Cash Limit (excluding NCL) - LHB & SHA	39,840	39,210	34,850	36,165	39,722	33,631	35,502	40,899	35,800	38,570	37,047	15,127
WG Revenue Funding - Non Cash Limited (NCL) - LHB & SHA only	(140)	(160)	(150)	(150)	(150)	(150)	(150)	(150)	(131)	(152)	(150)	(150)
WG Revenue Funding - Other (e.g. invoices)	405	4	289	4	18	76	1,061	57	4	1,100	50	2,000
WG Capital Funding - Cash Limit - LHB & SHA only	0	0	0	0	500	549	0	300	3,128	500	4,464	7,151
Income from other Welsh NHS Organisations	1,075	484	343	419	731	778	403	681	425	860	754	658
Sale of Assets	0	0	0	0	0	0	0	0	0	0	0	0
Other	1,439	587	502	653	1,179	686	860	567	700	500	400	1,600
Total Receipts	42,619	40,125	35,834	37,091	42,000	35,570	37,676	42,354	39,926	41,378	42,565	26,386
Payments												
Primary Care Services : General Medical Services	2,996	2,435	3,298	2,724	2,566	2,716	2,990	2,781	2,779	3,000	3,300	2,700
Primary Care Services : Pharmacy Services	274	1,161	0	391	929	0	425	1,087	319	450	450	450
Primary Care Services : Prescribed Drugs & Appliances	1,441	2,889	0	1,468	2,896	0	1,589	3,022	1,561	1,400	1,400	0
Primary Care Services : General Dental Services	478	426	474	484	523	367	439	407	494	500	500	0
Non Cash Limited Payments	86	130	152	135	134	118	117	137	116	100	100	100
Salaries and Wages	8,859	8,851	8,790	8,748	8,754	8,836	8,898	10,557	10,953	9,500	9,500	9,500
Non Pay Expenditure	28,499	23,660	22,123	23,872	24,374	24,565	21,428	24,655	23,123	23,704	24,009	26,570
Capital Payment	0	111	83	63	48	62	410	461	1,991	2,906	3,306	3,337
Other items	0	0	0	0	0	0	0	0	0	0	0	0
Total Payments	42,633	39,663	34,920	37,885	40,224	36,664	36,296	43,107	41,336	41,560	42,565	42,657
NET CASH FLOW IN MONTH	**(14)**	**462**	**914**	**(794)**	**1,776**	**(1,094)**	**1,380**	**(753)**	**(1,410)**	**(182)**	**0**	**(16,271)**
Balance c/f	**201**	**663**	**1,577**	**783**	**2,559**	**1,465**	**2,845**	**2,092**	**682**	**500**	**500**	**(15,771)**



Due to the £15.8m revised forecast financial deficit, the THB will require Strategic Cash in February 2025 to meet its obligations to suppliers and staff. An Accountable Officer letter has been sent formally requesting Strategic Cash.

Core Financial Plan Year 1 2024/25

Financial Plan	(£m)
Underlying Deficit	25.4
Inflationary Pressures	11.7
Demand / Service Growth	5.7
Net Effect of Allocation Adjustments and COVID	-10.0
Mitigating Actions	-9.9
Additional Funding from Welsh Government	-7.2
TOTAL DEFICIT	**15.8**

The original 2024/25 Financial Plan was a deficit of £24.9m.

The Health Board was asked to revisit the Financial Plan to reassess the underpinning assumptions and actions with an aim of reducing/ providing greater assurance on the forecast financial deficit.

Submission of supplementary papers and associated Minimum Data Set on 31 May 2024 revised the deficit financial plan to £22.9m, after £2.0m of additional savings were identified.

There is a range of significant risks to be managed.

Following the additional allocations of £7.178m in Month 8, the 2024/25 Financial Plan has been revised further. It aims to achieve a deficit £15.770m.

GIG CYMRU NHS WALES
Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 5.2

Delivery and Performance Committee	**Date: 06 February 2025**
Subject:	Powys Teaching Health Board Integrated Quality & Performance Report Scorecard – Month 9 (December 2024)
Presented by:	Executive Director of Planning, Performance and Commissioning
Approved by:	Assistant Director of Performance and Commissioning
Prepared by:	Head of Performance Administrative Officer, Integrated Performance
Other Committees and meetings considered at:	Informal Executive Committee - 30 January 2025

PURPOSE:

This Integrated Quality & Performance Report (IQPR) scorecard provides an update on the latest available performance position by exception for Powys Teaching Health Board against the NHS Wales Performance Framework 2024/25 up until the end of December 2024 (month 9).

RECOMMENDATION(S):

The Committee is asked to:

- **DISCUSS** the content of this report; and
- Take **ASSURANCE** that the Health Board has appropriate systems in place to monitor performance and respond to relevant issues.

Approve/Take Assurance	Discuss	Note
Y	Y	N

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	Y	
2. Provide Early Help and Support	Y	
3. Tackle the Big Four	Y	
4. Enable Joined up Care	Y	
5. Develop Workforce Futures	Y	
6. Promote Innovative Environments	Y	
7. Put Digital First	Y	
8. Transforming in Partnership	Y	

DELIVERY & PERFORMANCE COMMITTEE SUMMARY:

This report provides the Delivery and Performance Committee with the latest performance information to highlight performance achievements and challenges at a high level, as well as comparison to the All-Wales performance benchmark where available.

The month 9 IQPR scorecard version provides a performance update without Officer lead and Executive narrative input, this version is provided to give the committee the latest validated data available for discussion with Executive leads.

Summary for Month 9

Provider

Planned care:

- Diagnostic waits reported slight increased breaches with 84 reported in December vs 83 in November. Most breaches involve echocardiograms (73 pathways), endoscopy (3 pathways), and non-obstetric ultrasound (8 pathway). The health board is not achieving its ministerial priority trajectory although complexity around clinical practice change has increased echo cardiogram demand significantly.

  An operational review of capacity is being undertaken with additional clinics being undertaken in PTHB Community Cardiology service. A full evaluation of the service is to be undertaken to inform future plans for the service coverage to be expanded to mid and south Powys.

  Due to the agreed insourcing provision the position is projected to continue to improve to the end of March 2025 but it is not envisaged that the set trajectory of zero will be achieved.

- Referral to treatment (RTT) compliance remains positive :
  - 104-week waits: 0 pathways.
  - 52-week outpatient waits: 0 pathways.
  - 52-week treatment waits: increased breaches reporting 19 from the previous month (14).

- Therapies waits remain robust with 99.6% of under 18s seen within 14 weeks, and no adult breaches. 1 <18 pathway was reported in month as waiting longer than 14 weeks for Podiatry which is a particularly small speciality challenged by staffing fragility.

- Provider cancer pathway performance for outpatients and diagnostics remains robust with key diagnostics (endoscopy) being carried out within target. Downgrades within 28 days performance has improved to 35.7% but remains challenged by numerous factors including acute centre diagnostics and reporting delays.

- Overall performance broadly continues to improve aligned to national requirements and ministerial priorities. Challenges remain with in-reach capacity fragility, and complex diagnostic delays affecting specialties like Ophthalmology, ENT, and Orthopaedics. Insourced capacity remains in place to boost capacity especially for the key urgent and urgent suspected cancer pathways through quarter 4.

<u>Mental Health:</u>

- Under-18s: Compliance achieved in November for assessments, interventions, and care treatment plans (CTP).

- For Adults:
    - Assessments: Performance shows an increasing trend since August now reporting 71.4% against the target of 80%. It is expected that with the recruitment of 3 whole time equivalent mental health practitioners and agency mental health practitioner, this will significantly increase capacity for mental health assessments and that performance improvement will be sustained.

    - Interventions: Improved to 98.3%, significantly above the target of 80%.

    - CTP compliance: Has shown a decreasing trend since the summer with a further reduction in month to 80.7%, below the target of 90%. Performance has been impacted by sickness absence of two of the CMHT team leads. Both have returned with targeted piece of work undertaken with Ystradgynlais and Newtown Community Mental Health Teams (CMHTs) with expectation of improved performance position in December 2024 and sustained into 2025.

    - Psychological therapy waiting times reduced performance significantly to 63.1% in December (target: 80%). Performance impacted by new staff inductions, introduction of new allocation process, locum turnover and sickness absence. Plan for 2 new locums and additional administrative time over 3 months in Q4 to address waiting list reduction with expected improved position from January 2025. Work is ongoing to sustain performance thereafter but delays in recruitment to psychology posts will impact on this in the first quarter of 2025.

Neurodevelopmental Services:

- Significant challenges persist, with no improvement in performance against the nationally reported measure reported in December (27.3% compliance). Increased backlogs and waiting lists have led to escalation to internal oversight (Level 3).

- An improvement plan is in place:
  - Focused activity MDT discussions to support conclusions and outcomes planned for January 2025.
  - Recruitment of additional team members 3.6 wte to support ND assessments, to commence end of January 2025.
  - Procurement process in place, anticipated completion end of January 2025 with capacity available in February and March 2025 to further improve performance.

Emergency Care:

- Powys provider Minor Injuries Units (MIU) services performed very well, meeting the 4-hour target (100% compliance) and reporting median waits of 5 minutes for triage and 5 minutes for senior clinician assessment. This will be kept under review as the temporary service changes progress.

Commissioned services

Planned care:

- Long waits remain challenging, though Welsh providers show slow progress on RTT targets, and we are tracking the ongoing impact of the additional planned care funding that has been released to Welsh providers. Total waiting lists are growing, with increasing demand forecast to risk further breaches. Pathways in NHS England tend to result in faster treatment than NHS Wales, though key wait bands remain a concern. The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH) continue to have challenging long waits 2+ years for complex spinal pathways, and The Shrewsbury and Telford Hospital NHS Trust (SATH) are challenged with whole system pressures.

Cancer Pathways:

- Performance against the 62-day target remains poor in both English and Welsh commissioned services, with diagnostic delays, outpatient, and treatment capacity provided as key reason of delay via assurance and monitoring engagement. Wye Valley NHS Trust (WVT) is the only Commissioned provider that is showing consistent positive improvement towards English targets and reports better than All-England average for all measures.

Commissioned Emergency Care:

- Welsh Ambulance Service (WAST) 8-minute response times to RED calls remain poor reporting 45.2% in December.
- No commissioned service meets the required national 4 or 12hr targets for their A&E departments. However Welsh emergency department performance for Powys residents is better than the English counterparts, though significant delays persist, especially in ambulance handovers. It should be noted that The Shrewsbury and Telford Hospital NHS Trust (SATH) data has not been available since July-24 following reporting challenges.

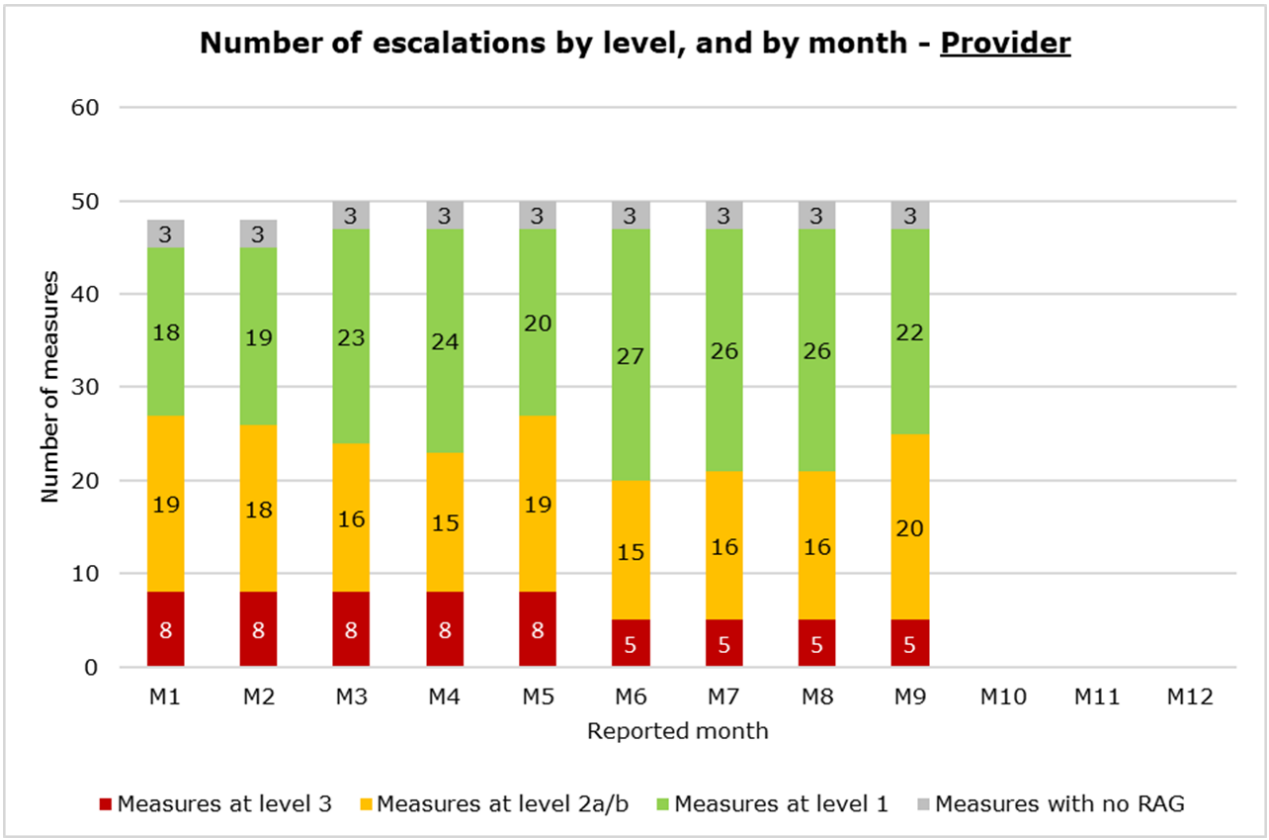
Month 9 measures by escalation level

There are a total of 50 reportable measures, with 5 remaining at level 3 as follows:

- Percentage of patients offered an index colonoscopy procedure within 4 weeks of booking their Specialist Screening Practitioner assessment appointment.
- Percentage of Local Primary Mental Health Support Service (LPMHSS) assessments undertaken within (up to and including) 28 days from the date of receipt of referral for adults aged 18 years and over.
- Number of patients waiting more than 8 weeks for a specified diagnostic.
- Number of patients waiting for a follow-up (FUP) outpatient appointment who are delayed by over 100% due to to data quality issues.
- Percentage of children and young people waiting less than 26 weeks to start an ADHD or ASD neurodevelopment assessment.

A further 20 are rated at level 2a, and 22 are achieving level 1 compliance e.g., no issues reported. To note measure 1 "Percentage of adult smokers who make a quit attempt via smoking cessation services" is rated as level 1, although not compliant in Q2 they are on track for meeting their respective end of year performance target (cumulative annual target). A further 3 health care acquired infections (HCAI) measures are currently non-rated with ongoing discussions by the Nursing Directorate and Welsh Government on integration into the national targets.

The following provides the relative performance of the Health Board against the NHS Performance Framework that is applicable to the provider e.g., no commissioned or local measures are accounted for even if they are listed within the below exception/escalation reports or other areas of the IQPR.



Key performance indicators 2024/25 (Health Board submitted trajectories)

For the December 2024 snapshot (where data is available) the Health Board reports compliance on 5 of 6 Powys applicable submitted key performance indicator trajectories. The measure unable to meet trajectory is "patients waiting over 8 weeks for a diagnostic" which misses trajectory of zero with 84 pathway breaches reported.

Please note that for the below tables scoring is colour and icon coded dependant on compliance of trajectory and national target, please note that:

- Value cell shading is red/green and denotes compliance to health board submitted trajectory as a key performance indicator.
- Value cell icon either green tick or red cross denotes compliance against the NHS Performance Framework target (mental health improvement trajectory targets match the NHS performance targets bar two with slight variation as noted in table).

Ministerial Priority Measures			Baseline		Month								
Measure	NHS Performance Target	KPI Improvement Target	Mar-24		Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Number of patients waiting more than 52 weeks for a new outpatient appointment	Zero	40% reduction by end of September 2024 Zero by March 2025	0	Performance trajectory	55	65	55	45	20	8	5	0	0
				Actual	✓ 0	✓ 0	✓ 0	✗ 1	✗ 1	✓ 0	✓ 0	✓ 0	✓ 0
Number of patients waiting more than 104 weeks for referral to treatment	Zero	Zero end of December 2024	1	Performance trajectory	0	0	0	0	0	0	0	0	0
				Actual	✓ 0	✗ 1	✗ 2	✗ 3	✗ 3	✓ 0	✓ 0	✓ 0	✓ 0
Number of patients waiting over 8 weeks for a specified diagnostic	Zero	95% to be zero by December 2024	116	Performance trajectory	230	200	150	75	30	0	0	0	0
				Actual	✗ 140	✗ 171	✗ 157	✗ 155	✗ 140	✗ 124	✗ 107	✗ 83	✗ 84
Number of patients who spend 12 hours or more in all major and minor emergency care facilities from arrival until admission, transfer or discharge	Zero	20% reduction by September 2024 Further 20% reduction by March 2025	0	Performance trajectory	0	0	0	0	0	0	0	0	0
				Actual	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0
Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS for people age under 18 years	80%	80% by December 2024	97.7%	Performance trajectory	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%
				Actual	✗ 80.0%	✓ 86.5%	✓ 83.7%	✓ 93.1%	✓ 90.0%	✓ 87.5%	✓ 92.1%	✓ 89.20%	
Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS for adults age 18 years and over	80%	80% by December 2024	91.1%	Performance trajectory	85.6%	85.6%	85.6%	85.6%	85.6%	85.6%	85.6%	85.6%	85.6%
				Actual	✓ 95.2%	✓ 95.3%	✓ 93.0%	✓ 95.10%	✓ 87.50%	✓ 91.7%	✓ 92.3%	✓ 98.30%	

Of the key mental health improvement trajectories submitted by the health board, 4 of the 9 performance orientated measures have achieved the health board trajectory as reported in the month 9 snapshot. Mental health data is often delayed and only neurodevelopmental and SCAMHS have been updated for December, but compliance is based off the latest available.

Policy Lead Priority Measures				Month								
Age Group	Measure	Target		Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Under 18's	Mental Health Measure Part 1a - % of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral	80%	Performance trajectory	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%
			Actual	✓ 98.0%	✓ 98.1%	✓ 100.0%	✓ 94.6%	✓ 100.0%	✓ 100.0%	✓ 100.0%	✓ 100.0%	
	Mental Health Measure Part 1b - % of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS	80% by December 2024 (80% monthly is NHS Performance Framework Target)	Performance trajectory	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%
			Actual	✓ 80.0%	✓ 86.5%	✓ 83.7%	✓ 93.1%	✓ 90.0%	✓ 87.5%	✓ 92.1%	✓ 89.2%	
	Mental Health Measure Part 2 - % of health board residents in receipt of secondary mental health services who have a valid care and treatment plan	90%	Performance trajectory	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%
			Actual	✓ 94.1%	✓ 93.9%	✓ 90.8%	✓ 91.0%	✓ 93.6%	✓ 94.9%	✓ 94.9%	✓ 97.8%	
	Neurodevelopmental - % of children and young people waiting less than 26 weeks to start an ADHS or ASD neurodevelopment assessment	80%	Performance trajectory	45.0%	45.0%	45.0%	45.0%	45.0%	45.0%	45.0%	45.0%	45.0%
			Actual	✗ 45.4%	✗ 45.8%	✗ 39.6%	✗ 42.0%	✗ 37.2%	✗ 34.3%	✗ 30.9%	✗ 30.5%	✗ 27.3%
	SCAMHS - % of patients waiting less than 28 days for a first appointment for sCAMHS	80%	Performance trajectory	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%
			Actual	✓ 98.0%	✓ 92.7%	✓ 93.8%	✓ 100.0%	✓ 100.0%	✓ 100.0%	✓ 100.0%	✓ 100.0%	✓ 97.1%
18 years and over	Mental Health Measure Part 1a - % of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral	80%	Performance trajectory	70.0%	70.0%	70.0%	75.0%	75.0%	75.0%	75.0%	75.0%	80.0%
			Actual	✗ 44.1%	✗ 54.1%	✗ 69.2%	✗ 74.0%	✗ 45.3%	✗ 46.7%	✗ 58.7%	✗ 71.4%	
	Mental Health Measure Part 1b - % of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS	80% by December 2024 (80% monthly is NHS Performance Framework Target)	Performance trajectory	86%	86%	86%	86%	86%	86%	86%	86%	86%
			Actual	✓ 95.2%	✓ 95.3%	✓ 93.0%	✓ 95.1%	✓ 87.5%	✓ 91.7%	✓ 92.3%	✓ 98.3%	
	Mental Health Measure Part 2 - % of health board residents in receipt of secondary mental health services who have a valid care and treatment plan	90%	Performance trajectory	80%	83%	86%	88%	90%	90%	90%	90%	90%
			Actual	✗ 89.0%	✗ 89.2%	✓ 90.1%	✗ 90.0%	✗ 88.9%	✗ 87.8%	✗ 85.9%	✗ 80.7%	
	Psychological Therapies - % of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health	80%	Performance trajectory	80.0%	83.0%	85.0%	88.0%	90.0%	93.0%	95.0%	95.0%	95.0%
			Actual	✗ 75.1%	✗ 69.4%	✗ 75.2%	✗ 76.9%	✗ 78.7%	✗ 79.9%	✗ 72.9%	✗ 67.0%	✗ 63.1%

NEXT STEPS:

- 2025/26 Performance Framework is now available, trajectory setting will be undertaken through Q4 2024/25.

Powell, Bethan 03/02/2025 16:55:30

IMPACT ASSESSMENT – NOT REQUIRED FOR THIS REPORT

Powys Teaching Health Board

Integrated Quality & Performance Report

Month 9 - Summary
Updated on 23/01/2025

Version – IQPR Scorecard update for Delivery and Performance Committee February 6th, 2025

Background of the IQPR

What is the Integrated Quality & Performance Report (IQPR)

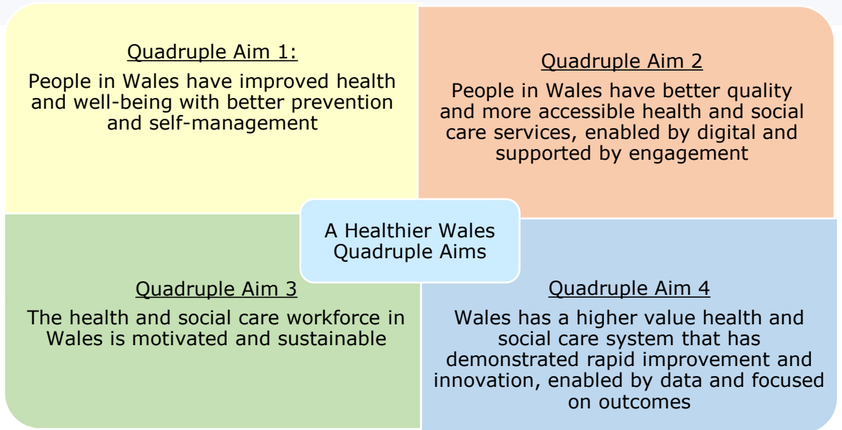
This report is a key part of the health boards Integrated Quality and Performance Framework (IQPF) designed to drive improvement in health board performance and health outcomes for those patients that Powys is responsible for.

The IQPR uses key NHS Performance Framework measures updated for 2024/25 which include Ministerial priorities and other timely local measures to provide robust assessment of the health boards performance as both a provider and commissioner of care focusing on key challenge and success.

This process utilises both quantitative and qualitative measurements which are backed by statistical process, business rules, and narrative provided by leads of the service area. The IQPR will continue to be developed with further inclusion of key measures.

What is the NHS Performance Framework?

The NHS Performance Framework is a key measurement tool for "A Healthier Wales" outcomes, The NHS Wales Quadruple Aim Outcomes are a set of four interconnected goals or aims that aim to guide and improve healthcare services in Wales. These aims were developed to enhance the quality of care, patient experience, and staff well-being within the National Health Service (NHS) in Wales. Link to the NHS Wales performance framework 2024 to 2025 | GOV.WALES



What is the Integrated Quality and Performance Framework (IQPF) in Powys?

The Integrated Quality & Performance Framework (IQPF) aims to report holistically at service, directorate or organisation level the performance of the resources deployed, and the outcomes being delivered. Overall performance assessed via intelligence gathered across key domains including activity, finance, workforce, quality, safety, outcomes and performance indicators.

The IQPF is a revision of the 2023/24 Integrated Performance Framework with a greater focus on quality, it remains undergoing phased implementation across the health board.

Key for the framework is they system review, reporting, escalation and assurance process that aligns especially to the NHS Performance measures and any priority trajectories. In the provider Integrated Quality & Performance Group meetings will address key challenges and provide a robust forum for support and escalation to Executive leads and provide actions and recovery trajectories for escalated metrics.

As part of the operationalisation of the IQPF there is an expected element of exception or escalation either in a clinical or corporate service area triggering cause for concern. In such circumstances the Clinical Service Area or corporate team may be put into an escalation arrangement. Escalation will be considered against 4 domains (Access & Activity; Finance & Value; Quality; Workforce & Culture) and 3 levels of escalation. The levels of the framework, triggers and escalation response are set out below.

1. Level 1 : Normal e.g., earned autonomy meeting key objectives
2. Level 2a : Failure to achieve / maintain delivery
3. Level 2b : Specific for financial overspend by more than £0.5m per year
4. Level 3 : Serious concerns on quality, governance, ongoing failure to achieve key priority metrics.
5. De-escalation : Challenge rectified, requirement change, or senior committee decision.

Link to escalation descriptor slide

PTHB Integrated Quality & Performance Framework Escalation Framework 2024/25

Please note that this framework replaces the 23/24 business reporting rules as used within the Integrated Performance Framework and report.

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Escalation level	Trigger	Action expected	Monitoring and support
Level 1 (No concerns)	• Local delivery of agreed objectives and performance, finance ambitions in line with agreed trajectories. • No exceptions or quality concerns. • Sound governance arrangements in place. • Performance within expected targets either national or local	• No escalation action. • Could result in frequency adjustment for some monitoring mechanisms and meetings including IQPG.	Main monitoring through base performance review process. Key measures bi-annually in IQPR to the Board.
Level 2a (Exception)	• Failure to achieve / maintain delivery in more than 1 key deliverable / area of performance. • Sustained deterioration on 1 or more domain. **This can include:** • Failure to deliver on an NHS Performance Framework target or local target trajectory. • A deviation or departure from the normal or expected course of action signifying specific condition or event that requires attention or further action to address the deviation. • Failure of quality standard. • Where SPC methodology notes variance of concern.	• Correspondence to Clinical service area/corporate dept on reasons for escalation – areas of concern, expected response and confirm any enhanced monitoring. • Recovery plan to be developed that address issues to be recovered/improved. • Depending on issue – change in frequency of and focus of standard meeting and consideration of increasing frequency including IQPG. • Reported through to Executive Committee. • Monthly reporting where appropriate via IQPR as an exception to performance.	**Options include:** • IQPG engagement monthly with Executive • Internal support as required (QI/vbhc/planning – issue dependent). • Consideration of compliance with Professional clinical codes and standards and proportionate response. • Consideration of compliance with managerial code of practice. • Internal peer review. • Executive support (directly or from other teams). • Consider need for bespoke response. • Minimum monthly updates to Executive Committee.
Level 2b (Exception)	**Specially for finance:** • Where Corporate Directorate or Clinical Service Area level budget is overspending by more than £0.5m Year to date or £1m forecast.	Identified through monthly financial reporting	CEO to call a special 'Budget Review Meeting' of all Executive Directors and the Divisional or Directorate budget holder (up to 3 team members may attend in support). **Agreed action plan established:** • Monitored through financial reporting arrangements. • Review period established if plan failing.
Level 3 (Escalation)	• Serious concerns on quality and governance. • Continued and consistent failure to meet agreed performance improvements and trajectories across a number of objectives. • Clear articulation of reasons for escalation and criteria for escalation. **This can include:** • Where a performance matter (exception) does not meet target and hits criteria for higher level of resolution, decision making or further action. • Any measure that continues to fail a health board submitted trajectory as part of the Ministerial Priority measures. • Performance recovery is failing to improve or maintain performance. • Any significant failure of quality standard. • Where IQPG deems that a service or measured outcome requires escalation resulting from identified challenge or significant concern.	• Correspondence to service area/corporate dept on reasons for escalation – areas of concern, expected response and confirm any enhanced monitoring. • Service Area or corporate directorate demonstrating recognition of issues and commitment to improve. • Improvement/recovery plan required to address issues identified. • Reported through to executive and relevant committee. • Escalated frequency of IQPG meetings and resultant remedial action plan completion. • Challenge review on appropriate shift to the Escalations Oversight Group (EOG). • Monthly reporting where appropriate via IQPR as an exception to performance.	**Actions could include:** • Escalation Oversight Group (EOG) • Independent review of service/corporate department effectiveness. • Deployment of appropriate HR policies e.g. Capability policy. • Weekly/fortnightly meetings with CEO and/or relevant execs to track progress against improvement actions (which directly related to de-escalation criteria). • Consideration of compliance with Professional clinical codes and standards and proportionate response. • Consideration of compliance with managerial code of practice. • Suspension or revision of service provision. **De-escalation:** The appropriate outcome for a challenge to be de-escalated. Either challenge has been rectified, requirement has changed, or via senior committee decision. A level 3 escalation may return to any previous lower level of escalation dependant on the remaining challenge and required monitoring.

Summary of Performance Provider – Month 9

Provider

Planned care:

- Diagnostic waits reported slight increased breaches with 84 reported in December vs 83 in November. Most breaches involve echocardiograms (73 pathways), endoscopy (3 pathways), and non-obstetric ultrasound (8 pathways). The health board is not achieving its ministerial priority trajectory although complexity around clinical practice change has increased echo cardiogram demand significantly. An operational review of capacity is being undertaken with additional clinics being undertaken in PTHB Community Cardiology service. A full evaluation of the service is to be undertaken to inform future plans for the service coverage to be expanded to mid and south Powys. Due to the agreed insourcing provision the position is projected to continue to improve to the end of March 2025 but it is not envisaged that the set trajectory of zero will be achieved.

- Referral to treatment (RTT) compliance remains positive :
  - 104-week waits: 0 pathways.
  - 52-week outpatient waits: 0 pathways.
  - 52-week treatment waits: increased breaches reporting 19 from the previous month (14).

- Therapies waits remain robust with 99.6% of under 18s seen within 14 weeks, and no adult breaches. 1 <18 pathway was reported in month as waiting longer than 14 weeks for Podiatry which is a particularly small speciality challenged by staffing fragility.

- Provider cancer pathway performance for outpatients and diagnostics remains robust with key diagnostics (endoscopy) being carried out within target. Downgrades within 28 days performance has improved to 35.7% but remains challenged by numerous factors including acute centre diagnostics and reporting delays.

- Overall performance broadly continues to improve aligned to national requirements and ministerial priorities. Challenges remain with in-reach capacity fragility, and complex diagnostic delays affecting specialties including Ophthalmology, ENT, and Orthopaedics. Insourced capacity remains in place to boost capacity especially for the key urgent and urgent suspected cancer pathways through quarter 4.

Mental Health:

- Under-18s: Compliance achieved in November for assessments, interventions, and care treatment plans (CTP).
- For Adults:
  - Assessments: Performance shows an increasing trend since August now reporting 71.4% against the target of 80%. It is expected that with the recruitment of 3 whole time equivalent mental health practitioners and agency mental health practitioner, this will significantly increase capacity for mental health assessments and that performance improvement will be sustained.
  - Interventions: Improved to 98.3%, significantly above the target of 80%.
  - CTP compliance: Has shown a decreasing trend since the summer with a further reduction in month to 80.7%, below the target of 90%. Performance has been impacted by sickness absence of two of the CMHT team leads. Both have returned with targeted piece of work undertaken with Ystradgynlais and Newtown Community Mental Health Teams (CMHTs) with expectation of improved performance position in December 2024 and sustained into 2025.
  - Psychological therapy waiting times reduced performance significantly to 63.1% in December (target: 80%). Performance impacted by new staff inductions, introduction of new allocation process, locum turnover and sickness absence. Plan for 2 new locums and additional administrative time over 3 months in Q4 to address waiting list reduction with expected improved position from January 2025. Work is ongoing to sustain performance thereafter but delays in recruitment to psychology posts will impact on this in the first quarter of 2025.

Neurodevelopmental Services:

- Significant challenges persist, with no improvement in performance against the nationally reported measure reported in December (27.3% compliance). Increased backlogs and waiting lists have led to escalation to internal oversight (Level 3).
- An improvement plan is in place:
  - Focused activity MDT discussions to support conclusions and outcomes planned for January 2025.
  - Recruitment of additional team members 3.6 whole time equivalent to support ND assessments, to commence end of January 2025.
  - Procurement process in place, anticipated completion end of January 2025 with capacity available in February and March 2025 to further improve performance.

Emergency Care:

- Powys provider Minor Injuries Units (MIU) services performed very well, meeting the 4-hour target (100% compliance) and reporting median waits of 5 minutes for triage and 5 minutes for senior clinician assessment. This will be kept under review as the temporary service changes progress.

Summary of Performance Commissioned – Month 9

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Commissioned services

Planned care:

- Long waits remain challenging, though Welsh providers show slow progress on RTT targets, and we are tracking the ongoing impact of the additional planned care funding that has been released to Welsh providers. Total waiting lists are growing, with increasing demand forecast to risk further breaches. Pathways in NHS England tend to result in faster treatment than NHS Wales, though key wait bands remain a concern. The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH) continue to have challenging long waits 2+ years for complex spinal pathways, and The Shrewsbury and Telford Hospital NHS Trust (SATH) are challenged with whole system pressures.

Cancer Pathways:

- Performance against the 62-day target remains poor in both English and Welsh commissioned services, with diagnostic delays, outpatient, and treatment capacity provided as key reason of delay via assurance and monitoring engagement. Wye Valley NHS Trust (WVT) is the only Commissioned provider that is showing consistent positive improvement towards English targets and reports better than All-England average for all measures.

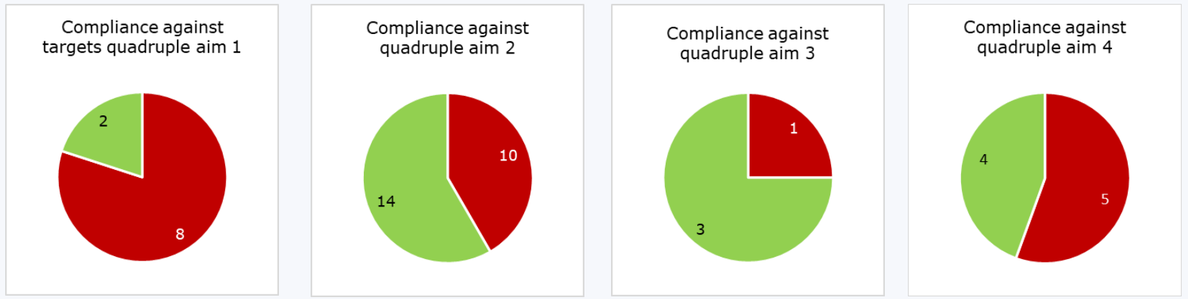
Commissioned Emergency Care:

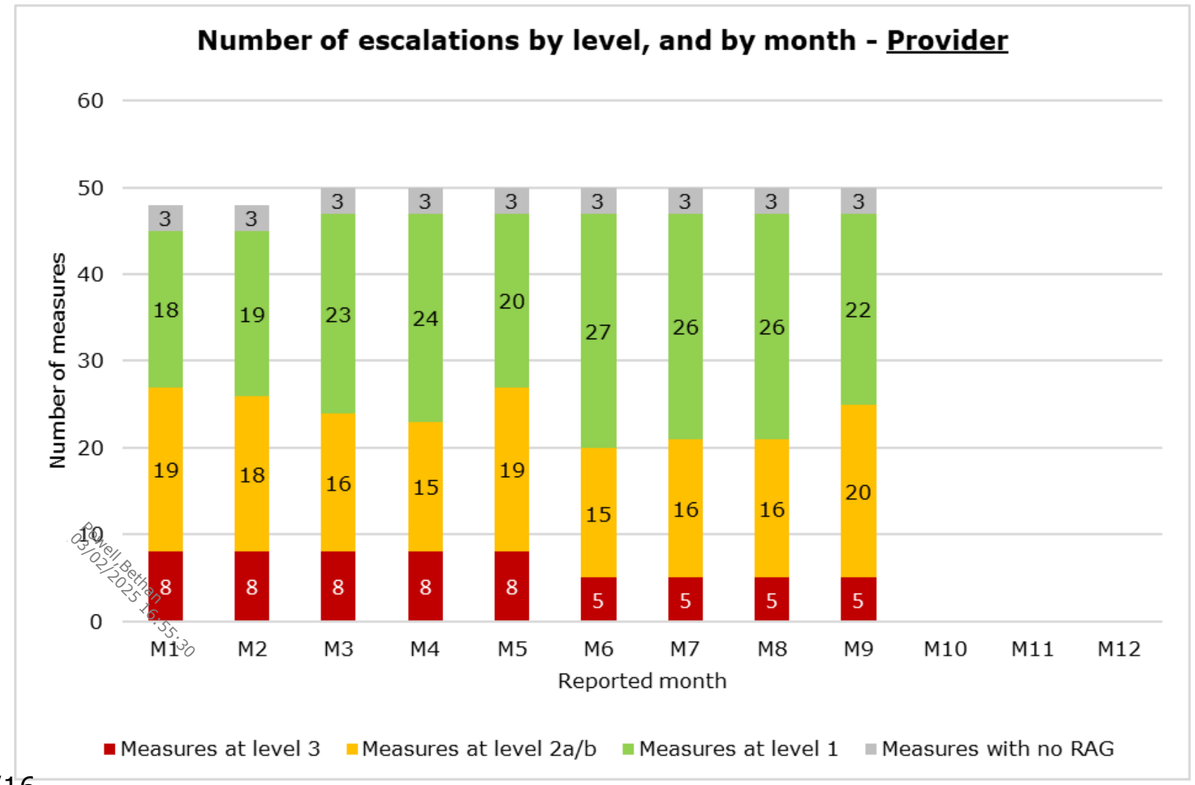
- Welsh Ambulance Service (WAST) 8-minute response times to RED calls remain poor reporting 45.2% in December.
- No commissioned service meets the required national 4 or 12hr targets for their A&E departments. However Welsh emergency department performance for Powys residents is better than the English counterparts, though significant delays persist, especially in ambulance handovers. It should be noted that The Shrewsbury and Telford Hospital NHS Trust (SATH) data has not been available since July-24 following reporting challenges.

Visual summary of performance at month 9 (December 2024)

Only measures with a compliance rating e.g., compliant (green), non-compliant (red) are included within the quadruple aims compliance pie charts.
No commissioned metrics are included within graphs below.
No non-RAG rated measures are included.

Compliance against NHS Performance Framework measures at month 9 by quadruple aim area.





- 50 quantitative measures as a provider are reportable of the 52 total in the NHS Performance Framework with the inclusion from June of median emergency unit wait times.
- This graph provides the relative performance of the health board against the NHS Performance Framework that is applicable to the provider e.g., no commissioned or local measures are accounted for even if they are listed within the below exception/escalation reports or other areas of the IQPR.
- It should also be noted however that any measure can have its escalation level raised or lowered by senior agreement for example serious concerns can result in a level 3 escalation, even if performance meets national target e.g., the escalation rating can override compliance against national target.
- Measures with no RAG rating are those with either insufficient data to determine compliance e.g. 12-month reduction trends (normally new metrics), and those where PTHB reports but has no national target as a non-acute provider.

Level 3 - Performance Challenges

Serious concerns on quality and governance or continued and consistent failure to meet agreed performance improvements and trajectories.

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No.	Measure description, target, performance and other information	Reason for escalation level	Key Performance Drivers	Key Actions
8	**Percentage of patients offered an index colonoscopy procedure within 4 weeks of booking their Specialist Screening Practitioner assessment appointment** Period: Oct-24 | Target: 90% | Actual: 0.0% | SPC icon	Escalated by Powys Performance team for historic and current poor target compliance	In-reach consultant unavailable during Q1 due to unplanned circumstances, backfill provided by in-source provider. In discussion with BSW to explore regional recruitment opportunities Q1 2024/25	Insourcing capacity continued from end of June to maximise capacity and provide opportunity to repatriate patients with screening provision in Mid-Powys currently being scoped. Agreed joint appointment of band 7 screening practitioner with CTMUHB, this role is now out for recruitment with plans to have staff member in place circa Q4. The measure performance is not reflective of PTHB access times as a provider with PTHB often achieving or exceeding the 4-week target. PTHB Performance Team resolving with Public Health Wales colleagues.
17	**Percentage of Local Primary Mental Health Support Service (LPMHSS) assessments undertaken within (up to and including) 28 days from the date of receipt of referral for adults aged 18 years and over** Period: Nov-24 | Target: 80% | Actual: 71.4% | SPC icon	Escalated by Powys Performance team for historic and current poor target compliance.	Staffing fragility including shortfall in administration capacity, practitioner sickness and vacancies, and summer annual leave at time of increased referrals.	Shortfall in administrative and clinical team staffing has impacted performance. Improvement is expected from December following successful recruitment of additional mental health practitioners which will significantly increase capacity for mental health assessments.
26	**Number of patients waiting more than 8 weeks for a specified diagnostic** Period: Dec-24 | Target: 0 | Actual: 84 | SPC icon	This metric has been escalated due to ongoing service pressure and non-compliance against Welsh Government set target. The service is reporting significant challenge of improvement and sustainability via the internal Performance and Engagement group linked to in-reach fragility.	Key challenge within Echo-cardiograms because of in-reach fragility of ABUHB. Patients are also now sent straight to test by consultant prior to first outpatient appointment increasing demand. Endoscopy challenged primarily through in-reach service capacity in South Powys. Increased demand and urgency. NOUS challenge linked to North Powys in-reach from BCUHB.	Cardiology in-reach service escalated via CQPRM with ABUHB. Operational review of capacity ongoing with additional clinics being undertaken within the PTHB Community Cardiology service. Full evaluation of Community Cardiology Service to be undertaken. Future plans for service to be expanded to mid and south Powys. Key use of agency to support NOUS.
31	**Number of patients waiting for a follow-up (FUP) outpatient appointment who are delayed by over 100%** Period: Dec-24 | Target: < same month pre. year | Actual: 1192 | SPC icon	FUP pathways recording and reporting was escalated in Q4 2021/22 following service identified significant accuracy challenge in the reporting of pathway time banding. Resulting reporting checks by the Powys Data Intelligence team highlighted a significant quantity of un-reported pathways and local reporting was aligned to the National WPAS team's process. This measure remains escalated until suitably resolved with Executive signoff.	Service pressure and demand to prioritise urgent and cancer pathways reducing FUP capacity. Ongoing data quality and validation challenges including patient administration system problems which are being resolved working with national team.	Ongoing validation work with Performance, Service, and Data & Business Intelligence (D&BI) department led by an Executive escalation group. SOS & PIFU reporting has now been resolved with the National Digital Team, improved local reporting identified and commenced to support national work stream.
34	**Percentage of children and young people waiting less than 26 weeks to start an ADHD or ASD neurodevelopment assessment** Period: Dec-24 | Target: 80% | Actual: 27.3% | SPC icon	Challenged whole pathway compliance with significant wait times for patients. Performance continues to fall against the measure and because of ongoing concern the Neurodevelopment service has been escalated to level 3. This service challenge has also triggered the Executive led Escalation Oversight Group process.	Referral demand on service has changed significantly post COVID. ND service in receipt of non-recurrent funding. Challenge of assessment backlog impacting on the waiting list.	Whole system review in progress to inform a sustainable business case for a future model of care. Welsh Government waiting time initiative announced October 2024 with key priorities that includes an immediate focus on reducing the ND service waiting times. Focused activity MDT discussions to support conclusions and outcomes. Recruitment of additional team members 3.6wte to support ND assessments, to commence end of January 2025. Procurement process in place, anticipated completion end of January 2025 with capacity available in February and March 2025 to further improve performance.

Quadruple Aim 1: Performance Scorecard

2024/25 Performance Framework Measures						Performance				SPC	Welsh Government Benchmarking (*in arrears)		IQPF Escalation
Area	Executive Lead	Officer Lead	No.	Abbreviated Measure Name	Target	Latest Available	12month Previous	Previous Period	Current	Icon	Ranking	All Wales	Level
Quadruple Aim 1: People in Wales have improved health and well-being with better prevention and self-management	Executive Director of Public Health	Consultant in Public Health	1	% Attempted to quit smoking	5% annual target	Q2 2024/25	2.55%	1.54%	2.75%	N/A	4th	2.63%	Level 1
	Executive Director of Public Health	Consultant in Public Health	2	% of Adult smokers who made a quit attempt via smoking cessation services who are CO-validated as quit at 4 weeks	40% annual target	Q2 2024/26		18.6%	15.6%	N/A	5th	16.56%	Level 2a
	Executive Director of Primary Care, Community and Mental Health	Assistant Director of Mental Health	3	Percentage of people who have been referred to health board services who have completed treatment for substance misuse (drugs/alcohol)	4 quarter improvement trend	Q2 2024/25	58.6%	70.8%	68.2%	N/A	3rd	57.7%	Level 1
	Executive Director of Public Health	Consultant in Public Health	4	% of children up to date with scheduled vaccinations by age 5	95%	Q2 2024/25	89.8%	91.1%	93.0%	N/A	1st	87.8%	Level 2a
	Executive Director of Public Health	Consultant in Public Health	5	% of children receiving the HPV vaccination by the age of 15	90%	Q2 2024/25	81.2%	78.4%	78.6%	N/A	3rd	75.6%	Level 2a
			6	Flu Vaccines - 65+	75%	Dec-24	68.0%	61.2%	66.9%	N/A	4th	67.9%	Level 2a
			7	% uptake of COVID-19 vaccination for those eligible (Autumn booster)	75%	Dec-24	60.3%	38.9%	48.6%	N/A	1st	43.2%	Level 2a
	Executive Director of Primary Care, Community and Mental Health	Senior Manager - Planned Care	8	% of patients offered an index colonoscopy within 4 weeks of booking specialist screening appointment	90%	Oct-24	0.0%	6.7%	0.0%		7th	30.2%	Level 3
	Executive Director of Nursing, Quality, Womens and Family Health	Assistant Director of Women's and Childrens Services	9	% of well babies completing the hearing screening programme within 4 weeks	90%	Oct-24	91.9%	93.2%	93.4%		7th	97.7%	Level 1
			10	% of eligible newborn babies who have a conclusive bloodspot screening result by day 17	95%	Nov-24	97.6%	96.2%	93.0%		7th	97.3%	Level 2a

Quadruple Aim 2: Performance Scorecard

2024/25 Performance Framework Measures					Performance					SPC	Welsh Government Benchmarking (*in arrears)		IQPF Escalation
Area	Executive Lead	Officer Lead	No.	Abbreviated Measure Name	Target	Latest Available	12month Previous	Previous Period	Current	Icon	Ranking	All Wales	Level
Quadruple Aim 2: People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement	Executive Director of Primary Care, Community and Mental Health	Assistant Director of Primary Care	11	% of GP practices that have achieved all standards set out in the National Access Standards for In-hours GMS	100%	2023/24	100.0%		100.0%	N/A	1st	97.3%	Level 1
			12	% of patients (aged 12+) with diabetes who received all 8 NICE recommended care processes	Improvement compared to the same month in the previous year	Dec-24	48.6%	48.6%	48.5%		1st	41.5%	Level 2a
		Assistant Director of Primary Care	13	% of the primary care dental services (GDS) contract value delivered (for courses of treatment for new, new urgent and historic patients)	A month on month increase towards a minimum of 30% contract value delivered by 30	Nov-24	53.5%	41.5%	48.6%		5th	56.8%	Level 1
	Executive Medical Director	Chief Pharmacist	14	No of consultations delivered through the Pharmacist Independent Prescribing Service (PIPS)	Increase compared to the same month in the previous year	Nov-24	409	471	438		7th	13,632	Level 1
	Executive Director of Primary Care, Community and Mental Health	Assistant Director of Mental Health	15	Assessments <28 days <18	80%	Nov-24	100.0%	100.0%	100.0%		1st	93.2%	Level 1
			16	Interventions <28 days <18	80%	Nov-24	88.1%	92.1%	89.2%		4th	59.5%	Level 1
			17	Assessments <28 days 18+	80%	Nov-24	89.1%	58.7%	71.4%		6th	73.5%	Level 3
			18	Interventions <28 days 18+	80%	Nov-24	49.2%	92.3%	98.3%		3rd	51.5%	Level 1
	Executive Director of Planning, Performance and Commissioning	Assistant Director of Performance and Commissioning	19	Percentage of emergency responses to red calls arriving within (up to and including) 8 minutes	65%	Dec-24	42.4%	47.6%	45.2%		6th	47.6%	Level 2a
			20	Median emergency response time to amber calls	12 month reduction trend	Dec-24	00:54:13	01:04:27	01:21:06		1st	03:01:43	Level 2a
	Executive Director of Planning, Performance and Commissioning	Assistant Director of Performance and Commissioning	21	Median time from arrival at an emergency department to triage by a clinician	15 minutes or less	Dec-24	4	5	4	N/A	PTHB is not nationally benchmarked against this measure		Level 1
			22	Median time from arrival at an emergency department to assessment by a senior clinical decision maker	60 minutes or less	Dec-24	5	5	4	N/A			Level 1
	Executive Director of Primary Care, Community and Mental Health	Senior Manager Unscheduled Care	23	% of patients who spend less than 4 hours in all major & minor emergency care facilities from arrival until admission, transfer or discharge	Improvement compared to the same month in the previous year, towards the national target of 95%	Dec-24	100.0%	100.0%	100.0%		1st	64.8%	Level 1
			24	Number of patients who spend 12 hours or more in all hospital major and minor emergency care facilities from arrival until admission, transfer or discharge	Reduction compared to the same month in the previous year, towards the national target of zero	Dec-24	0	0	0		1st	10,857	Level 1

Quadruple Aim 2: Performance Scorecard

2024/25 Performance Framework Measures						Performance				SPC	Welsh Government Benchmarking (*in arrears)		IQPF Escalation
Area	Executive Lead	Officer Lead	No.	Abbreviated Measure Name	Target	Latest Available	12month Previous	Previous Period	Current	Icon	Ranking	All Wales	Level
Quadruple Aim 2: People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement	Executive Director of Primary Care, Community and Mental Health	Assistant Director of Community Services	26	Number of diagnostic breaches 8+ weeks	0	Dec-24	192	83	84		1st	40,941	Level 3
			27	% of children <18 waiting 14 weeks or less for a specified AHP	100%	Dec-24	84.2%	99.7%	99.6%		1st	88.5%	Level 2a
			28	Number of therapy breaches 14+ weeks (all ages)	0	Dec-24	343	1	1		1st	5,117	Level 2a
			29	Number of patients (adult hearing aids only) waiting more than 14 weeks	0	Dec-24	79	0	0		1st	4,074	Level 1
			30	Number of patients waiting >52 weeks for a new outpatient appointment	0	Dec-24	19	0	0		1st	82,335	Level 1
			31	Number of patient follow-up outpatient appointment delayed by over 100%	Reduction compared to the same month in the previous year	Dec-24	1568	1073	1192		1st	242,552	Level 3
			32	RTT patients waiting more than 104 weeks	0	Dec-24	0	0	0		1st	24,361	Level 1
			33	RTT patients waiting more than 52 weeks	Month on month reduction towards the national target of zero by 30 June 2025	Dec-24	58	14	19		1st	173,768	Level 2a
	Executive Director of Nursing, Quality, Womens and Family Health	Assistant Director of Women's and Children's	34	Children/Young People neurodevelopmental waits	80%	Dec-24	51.5%	30.5%	27.3%		3rd*	21.5%	Level 3
	Executive Director of Primary Care, Community and Mental Health	Assistant Director of Mental Health	35	Adult psychological therapy waiting < 26 weeks	80%	Dec-24	86.6%	67.0%	63.1%		3rd*	59.0%	Level 2a

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Quadruple Aim 3: Performance Scorecard

2024/25 Performance Framework Measures					Performance					SPC	Welsh Government Benchmarking (*in arrears)		IQPF Escalation
Area	Executive Lead	Officer Lead	No.	Abbreviated Measure Name	Target	Latest Available	12month Previous	Previous Period	Current	Icon	Ranking	All Wales	Level
Quadruple Aim 3: The health and social care workforce in Wales is motivated and sustainable	Executive Director of People and Culture	Deputy Director of People and Culture	36	(R12) Sickness Absence	12 month reduction trend	Dec-24	5.4%	5.2%	5.2%		5th (Oct-24)	6.2%	Level 1
			37	Turnover rate for nurse and midwifery registered staff leaving NHS Wales	Rolling 12 month reduction against a baseline of 2019/20	Sep-24	13.0%	9.0%	8.4%		8th	6.1%	Level 1
	Executive Director of Primary Care, Community and Mental Health	Assistant Director of Community Services Group	38	Agency spend as a percentage of the total pay bill	12 month reduction trend	Dec-24	11.4%	7.7%	8.3%		12th (Oct-24)	3.1%	Level 1
	Executive Director of People and Culture	Deputy Director of People and Culture	39	Performance Appraisals (PADR)	85%	Dec-24	78.3%	82.8%	82.3%		5th (Oct-24)	77.0%	Level 2a

Quadruple Aim 4: Performance Scorecard

2024/25 Performance Framework Measures						Performance				SPC	Welsh Government Benchmarking (*in arrears)		IQPF Escalation
Area	Executive Lead	Officer Lead	No.	Abbreviated Measure Name	Target	Latest Available	12month Previous	Previous Period	Current	Icon	Ranking	All Wales	Level
Quadruple Aim 4: Wales has a higher value health and social care system that has demonstrated rapid improvement and innovation, enabled by data and focused on outcomes	Executive Director of Allied Health Professions, Health Sciences and Digital	Head of Information-Digital Transformation and Informatics	40	% of episodes clinically coded within one month post discharge end date	Maintain 95% target or demonstrate an improvement trend over 12 months	Oct-24	100.0%	100.0%	100.0%		1st	68.3%	Level 1
			41	% of all classifications' coding errors corrected by the next monthly reporting submission	90%	Oct-24	100.0%	100.0%	100.0%		1st	75.8%	Level 1
	Executive Director of Primary Care, Community and Mental Health	Assistant Director of Community Services	42	% of calls ended following WAST telephone assessment (Hear and Treat)	17% or more	Apr-24	9.4%	10.5%	10.3%		7th	15.2%	Level 2a
			43	No of Pathways of Care delayed discharges	12 month reduction trend	Dec-24	56	63	66		2nd	1,435	Level 2a
		Assistant Director of Mental Health	44	% residents with CTP <18	90%	Nov-24	90.2%	94.9%	97.8%		3rd	94.9%	Level 1
			45	% residents with CTP 18+	90%	Nov-24	81.0%	85.9%	80.7%		6th	82.4%	Level 2a
	Executive Director of Nursing, Quality, Women and Family Health	Assistant Director of Quality & Safety	46	Number of service user feedback experience responses completed and recorded on CIVICA	Month on Month Improvement	Dec-24	295	250	221		8th	21,055	Level 1
	Executive Director of Nursing, Quality, Women and Family Health	Deputy Director of Nursing	47	HCAI - Klebsiella sp and Aeruginosa cumulative number	Health Board Specific Target	Dec-24	0	0	0		PTHB is not nationally benchmarked for infection rates		
			48	HCAI - E.coli, S.aureus bacteraemia's (MRSA and MSSA) - Cumulative rate of confirmed cases per 100,000	Health Board Specific Target	Dec-24	3	1.12	1.12				
			49	HCAI - cumulative rate of C.Difficile cases per 100,000 population	Health Board Specific Target	Dec-24	18.01	21.23	19.83				
	Executive Director of Primary Care, Community and Mental Health	Assistant Director of Community Services	51	Percentage of ophthalmology R1 patients who attended within their clinical target date (+25%)	12 month improvement trend towards national target of 95%	Dec-24	65.6%	69.8%	75.1%		1st	65.6%	Level 1
	Executive Director of Nursing, Quality, Women and Family Health	Assistant Director of Quality & Safety	54	No of patient safety incidents that remain open 90 days or more	12 month reduction trend	Dec-24	4	14	14		4th	228	Level 2a

Commissioned and Local Measures

Commissioned and Local Measures						Performance				SPC	IQPF Escalation
Area	Executive Lead	Officer Lead	No.	Abbreviated Measure Name	Target	Latest Available	12month Previous	Previous Period	Current	Icon	Level
Planned Care & Cancer	Executive Director of Primary Care, Community and Mental Health	Assistant Director of Community Service Group	Local Measure	Powys provider cancer pathways additions and downgrade performance against 28-day NICE guidance of best practice - SCP Referrals into Powys Provider	N/A	Nov-24	46.0	30.0	35.0		Level 2a
			Local Measure	Powys provider cancer pathways additions and downgrade performance against 28-day NICE guidance of best practice - SCP Downgrades within 28 days best practice	N/A	Nov-24	13.9%	35.1%	35.7%		Level 2a
Quality & Safety	Executive Director of Nursing, Quality, Women and Family Health	Assistant Director Quality & Safety	Local Measure	Patient safety notice/alerts compliance	N/A	Jan-24			100.0%	N/A	
			Local Measure	Total complaints settled within final reply (Reg24) - % settled within 30 days	75%	Apr-24 - Oct-24			80.0%	N/A	
			Local Measure	Reported never events	N/A	Dec-24			0	N/A	
			Local Measure	National reportable incident rate per 100k pop.	N/A	Dec-24			1.20	N/A	
Commissioned Services - RTT	Executive Director of Planning, Performance and Commissioning	Assistant Director of Performance and Commissioning	Local Measure	Welsh Commissioned RTT - Over 36 weeks	Individual Health Board recovery targets aligned to Ministerial priorities.	Dec-24	2300	2549	2595		Level 3
			33	Welsh Commissioned RTT - Over 52 weeks		Dec-24	1342	1488	1528		Level 3
			32	Welsh Commissioned RTT - Over 104 weeks		Dec-24	260	194	195		Level 3
			Local Measure	English Commissioned RTT - Over 36 weeks	NHSE set targets for RTT	Oct-24	2314	3009	3116		Level 3
			33	English Commissioned RTT - Over 52 weeks		Oct-24	882	1184	1218		Level 3
			32	English Commissioned RTT - Over 104 weeks		Oct-24	16	40	36		Level 3
			Local Measure	Private dermatology service provider RTT performance - Over 36 weeks	Service targets assurance aligned to NHS Wales targets & KPI's	Nov-24	24	6	15	N/A	Level 2a
			Local Measure	Private dermatology service provider RTT performance - Over 52 weeks		Nov-24	3	0	0	N/A	Level 1

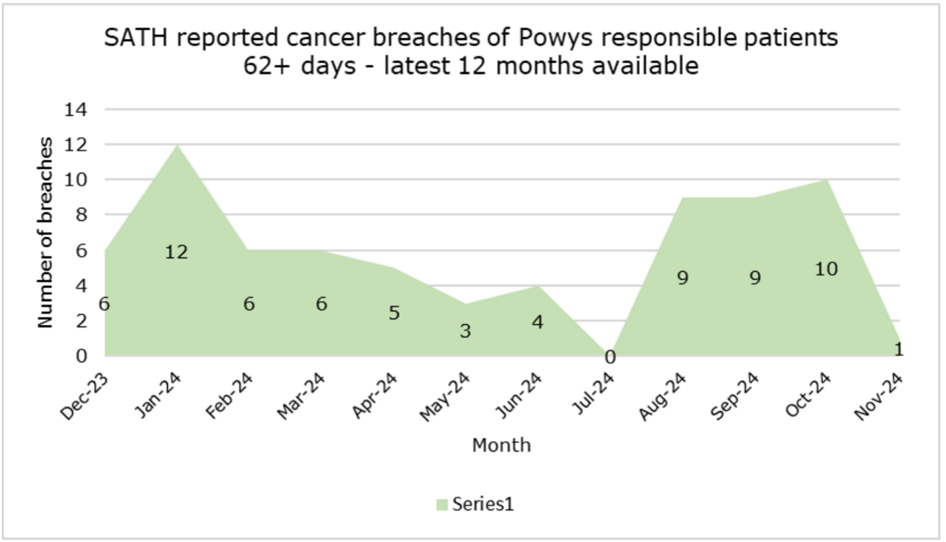
Commissioned and Local Measures – November 2024

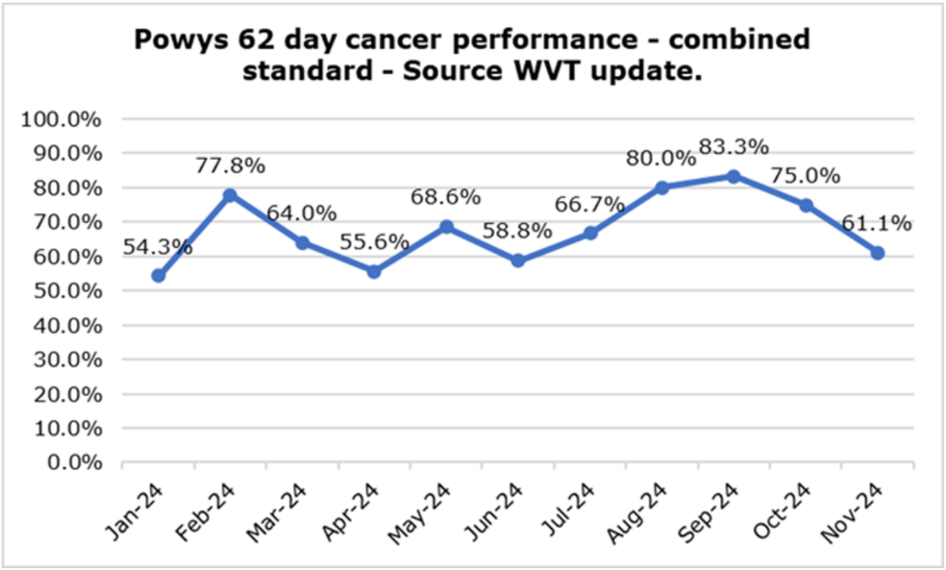
Single cancer pathway compliance – Welsh Commissioned providers – Source DHCW

HealthBoard	2024-04	2024-05	2024-06	2024-07	2024-08	2024-09	2024-10	2024-11
Aneurin Bevan UHB								
Pathways With Treatment	18	10	11	18	15	11	9	13
Treated Within 62 Days	11	5	9	10	9	7	8	7
Breaching 62 Day Target	7	5	2	8	6	4	1	6
% Treated Within Target	61%	50%	82%	56%	60%	64%	89%	54%
Betsi Cadwaladr UHB								
Pathways With Treatment				4	1	1	1	2
Treated Within 62 Days							1	2
Breaching 62 Day Target				4	1	1		
% Treated Within Target				0%	0%	0%	100%	100%
Cardiff And Vale UHB								
Pathways With Treatment					1			
Treated Within 62 Days					1			
Breaching 62 Day Target								
% Treated Within Target					100%			
Cwm Taf Morgannwg UHB								
Pathways With Treatment	4	4	3	3	6	6	5	3
Treated Within 62 Days	1	1	1	1	3	2	4	
Breaching 62 Day Target	3	3	2	2	3	4	1	3
% Treated Within Target	25%	25%	33%	33%	50%	33%	80%	0%
Hywel Dda UHB								
Pathways With Treatment	9	8	8	9	8	8	6	8
Treated Within 62 Days	3	3	5	6	6	5	2	7
Breaching 62 Day Target	6	5	3	3	2	3	4	1
% Treated Within Target	33%	38%	63%	67%	75%	63%	33%	88%
Swansea Bay UHB								
Pathways With Treatment	8	7	11	10	12	7	9	9
Treated Within 62 Days	6	6	5	8	6	5	5	5
Breaching 62 Day Target	2	1	6	2	6	2	4	4
% Treated Within Target	75%	86%	45%	80%	50%	71%	56%	56%
Pathways With Treatment	**39**	**29**	**33**	**44**	**43**	**33**	**30**	**35**
Treated Within 62 Days	**21**	**15**	**20**	**25**	**25**	**19**	**20**	**21**
Breaching 62 Day Target	**18**	**14**	**13**	**19**	**18**	**14**	**10**	**14**
% Treated Within Target	**54%**	**52%**	**61%**	**57%**	**58%**	**58%**	**67%**	**60%**

Closed Pathways - Nov 24 - suspicion to treatment days of wait band (target within 62 days)

HealthBoard	0-14 days	15 to 28 days	29-62 days	63-104 days	105-200 days	over 300 days	Total
Aneurin Bevan UHB	2	1	4	4	2		**13**
Betsi Cadwaladr UHB		1	1				**2**
Cwm Taf Morgannwg UHB					2	1	**3**
Hywel Dda UHB	1		6		1		**8**
Swansea Bay UHB		2	3	3	1		**9**
Total	**3**	**4**	**14**	**7**	**6**	**1**	**35**





NHS Executive Key Performance Indicator Trajectories – Submitted May 2024

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

At the start of 2024/25 financial year NHS Executive wrote to all health boards and trusts setting out a requirement for improved waiting times, this to drive improvements in patient care and experience. Five areas were highlighted, and minimum access targets provided. As a health board PTHB provided trajectories to meet or exceed these minimum planned care targets to achieve the targets.

The below table contains submission trajectories and is colour and icon coded dependant on compliance, please note that:
- Value cell shading red/green, this denotes compliance to health board submitted trajectory as a key performance indicator
- Value cell icon either green tick or red cross denotes compliance against the NHS Performance Framework target.

Ministerial Priority Measures			Baseline		Month								
Measure	NHS Performance Target	KPI Improvement Target	Mar-24		Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Number of patients waiting more than 52 weeks for a new outpatient appointment	Zero	40% reduction by end of September 2024 Zero by March 2025	0	Performance trajectory	55	65	55	45	20	8	5	0	0
				Actual	✓ 0	✓ 0	✓ 0	✗ 1	✗ 1	✓ 0	✓ 0	✓ 0	✓ 0
Number of patients waiting more than 104 weeks for referral to treatment	Zero	Zero end of December 2024	1	Performance trajectory	0	0	0	0	0	0	0	0	0
				Actual	✓ 0	✗ 1	✗ 2	✗ 3	✗ 3	✓ 0	✓ 0	✓ 0	✓ 0
Number of patients waiting over 8 weeks for a specified diagnostic	Zero	95% to be zero by December 2024	116	Performance trajectory	230	200	150	75	30	0	0	0	0
				Actual	✗ 140	✗ 171	✗ 157	✗ 155	✗ 140	✗ 124	✗ 107	✗ 83	✗ 84
Number of patients who spend 12 hours or more in all major and minor emergency care facilities from arrival until admission, transfer or discharge	Zero	20% reduction by September 2024 Further 20% reduction by March 2025	0	Performance trajectory	0	0	0	0	0	0	0	0	0
				Actual	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0
Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS for people age under 18 years	80%	80% by December 2024	97.7%	Performance trajectory	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%
				Actual	✓ 80.0%	✓ 86.5%	✓ 83.7%	✓ 93.1%	✓ 90.0%	✓ 87.5%	✓ 92.1%	✓ 89.20%	
Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS for adults age 18 years and over	80%	80% by December 2024	91.1%	Performance trajectory	85.6%	85.6%	85.6%	85.6%	85.6%	85.6%	85.6%	85.6%	85.6%
				Actual	✓ 95.2%	✓ 95.3%	✓ 93.0%	✓ 95.10%	✓ 87.50%	✓ 91.7%	✓ 92.3%	✓ 98.30%	

Mental Health performance improvement trajectories 2024/25 – Submitted May 2024

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

At the start of 2024/25 financial year Welsh Government policy and performance leads requested trajectories to support internal NHS Wales delivery assurance process for the operational delivery of mental health performance, forming part of routine mental health touchpoint meetings with Health Board colleagues as well as Integrated Quality, Planning and Delivery meetings between Health Boards, Welsh Government and the NHS Executive.

The below table contains key elements for the submitted trajectories and is colour and icon coded dependant on compliance, please note that:

- Value cell shading red/green, this denotes compliance to health board submitted trajectory as a key mental health performance indicator
- Value cell icon either green tick ✓ or red cross ✗ denotes compliance against the NHS Performance Framework target.

Policy Lead Priority Measures				Month								
Age Group	Measure	Target		Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Under 18's	Mental Health Measure Part 1a - % of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral	80%	Performance trajectory	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%
			Actual	✓ 98.0%	✓ 98.1%	✓ 100.0%	✗ 94.6%	✓ 100.0%	✓ 100.0%	✓ 100.0%	✓ 100.0%	
	Mental Health Measure Part 1b - % of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS	80% by December 2024 (80% monthly is NHS Performance Framework Target)	Performance trajectory	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%
			Actual	✓ 80.0%	✓ 86.5%	✓ 83.7%	✓ 93.1%	✓ 90.0%	✓ 87.5%	✓ 92.1%	✓ 89.2%	
	Mental Health Measure Part 2 - % of health board residents in receipt of secondary mental health services who have a valid care and treatment plan	90%	Performance trajectory	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%
			Actual	✓ 94.1%	✓ 93.9%	✓ 90.8%	✓ 91.0%	✓ 93.6%	✓ 94.9%	✓ 94.9%	✓ 97.8%	
	Neurodevelopmental - % of children and young people waiting less than 26 weeks to start an ADHS or ASD neurodevelopment assessment	80%	Performance trajectory	45.0%	45.0%	45.0%	45.0%	45.0%	45.0%	45.0%	45.0%	45.0%
			Actual	✗ 45.4%	✗ 45.8%	✗ 39.6%	✗ 42.0%	✗ 37.2%	✗ 34.3%	✗ 30.9%	✗ 30.5%	✗ 27.3%
	SCAMHS - % of patients waiting less than 28 days for a first appointment for sCAMHS	80%	Performance trajectory	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%
			Actual	✓ 98.0%	✓ 92.7%	✓ 93.8%	✓ 100.0%	✓ 100.0%	✓ 100.0%	✓ 100.0%	✓ 100.0%	✓ 97.1%
18 years and over	Mental Health Measure Part 1a - % of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral	80%	Performance trajectory	70.0%	70.0%	70.0%	75.0%	75.0%	75.0%	75.0%	75.0%	80.0%
			Actual	✗ 44.1%	✗ 54.1%	✗ 69.2%	✗ 74.0%	✗ 45.3%	✗ 46.7%	✗ 58.7%	✗ 71.4%	
	Mental Health Measure Part 1b - % of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS	80% by December 2024 (80% monthly is NHS Performance Framework Target)	Performance trajectory	86%	86%	86%	86%	86%	86%	86%	86%	86%
			Actual	✓ 95.2%	✓ 95.3%	✓ 93.0%	✓ 95.1%	✓ 87.5%	✓ 91.7%	✓ 92.3%	✓ 98.3%	
	Mental Health Measure Part 2 - % of health board residents in receipt of secondary mental health services who have a valid care and treatment plan	90%	Performance trajectory	80%	83%	86%	88%	90%	90%	90%	90%	90%
			Actual	✗ 89.0%	✗ 89.2%	✓ 90.1%	✗ 90.0%	✗ 88.9%	✗ 87.8%	✗ 85.9%	✗ 80.7%	
	Psychological Therapies - % of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health	80%	Performance trajectory	80.0%	83.0%	85.0%	88.0%	90.0%	93.0%	95.0%	95.0%	95.0%
			Actual	✗ 75.1%	✗ 69.4%	✗ 75.2%	✗ 76.9%	✗ 78.7%	✗ 79.9%	✗ 72.9%	✗ 67.0%	✗ 63.1%

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Integrated Plan Progress Report

Quarter 3 2024/ 2025

October to December 2024

BRAGG Key

Blue - Complete
Red - Behind schedule
Amber - At risk/issues present
Green - On track
Grey – Not due yet

PLAN ON A PAGE 2024 - 2029

Plan on a page 2024 - 2029

Better Together for a Sustainable Model of Care

Whole System Approach to Wellbeing & Prevention

- Develop a whole system prevention plan *across the life course*
- Deliver a Health Protection response *including Vaccination*

Faster, effective diagnosis and treatment

- Improve access to Primary and Community Care
- Design and Deliver a phased Frailty and Community Model
- Deliver the Planned Care and Diagnostics Programme

Working together across Major Conditions, Physical and Mental Health

- Develop and deliver a Major Conditions Plan *respiratory & circulatory health (cardiac, diabetes, stroke) and cancer*
- Deliver the Mental Health Transformation Programme

Home first and back home fitter and faster

- Improve pathways of care *focused on system flow*
- Deliver the Six Goals Plan for Urgent and Emergency Care *focusing on what works for the Powys population*

WORKFORCE FUTURES

DIGITAL FIRST

INNOVATIVE ENVIRONMENTS

TRANSFORMING IN PARTNERSHIP

Quality is the golden thread across the whole plan

- Underpinned by the Quality Standards: Safe, Timely, Effective, Efficient, Equitable, Person-Centred (STEEEP)
- Delivery of Duty of Quality and Duty of Candour Action Plans
- Interdependencies across the plan in relation to a **Value** based approach and effective **Governance**

WG TEMPLATE Primary & Community Care

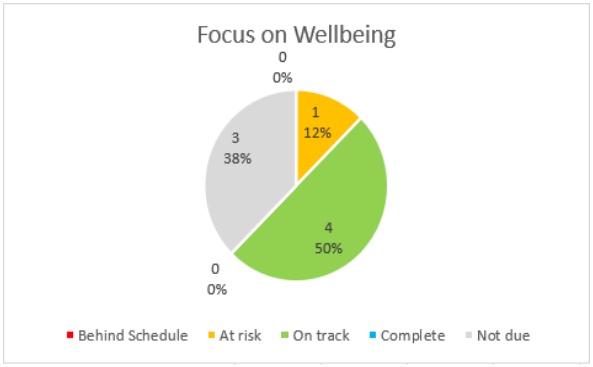
WG TEMPLATE Enhanced Care in the Community (Pathways of Care)

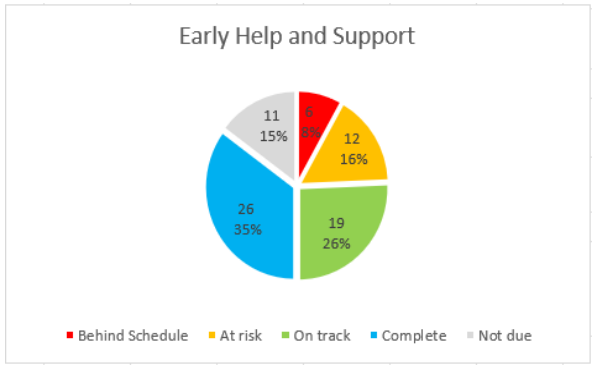
WG TEMPLATE Planned Care & Cancer

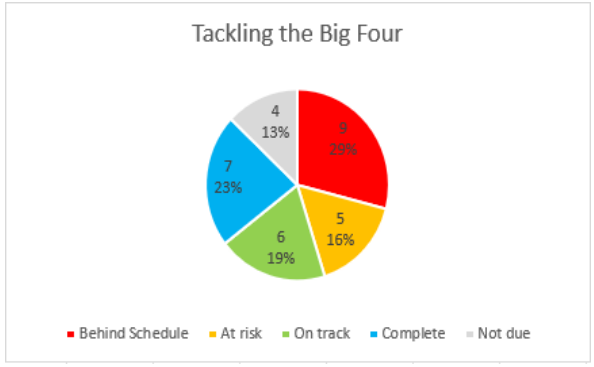
WG TEMPLATE Mental Health

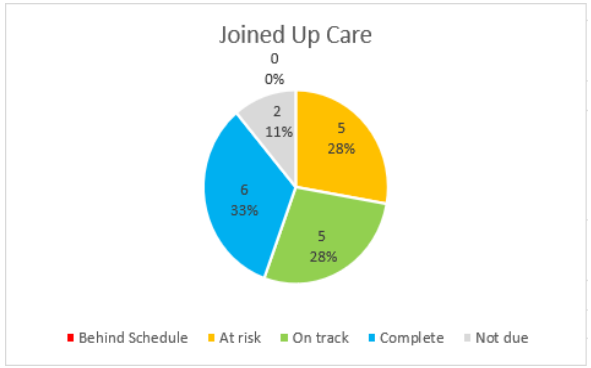
WG TEMPLATE Urgent and Emergency Care / Six Goals

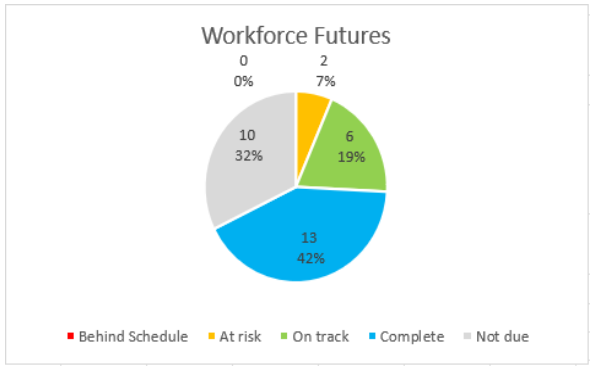
CONSOLIDATED YEAR TO DATE SUMMARY

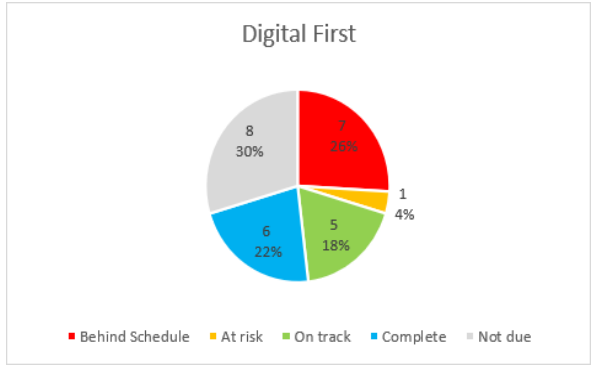


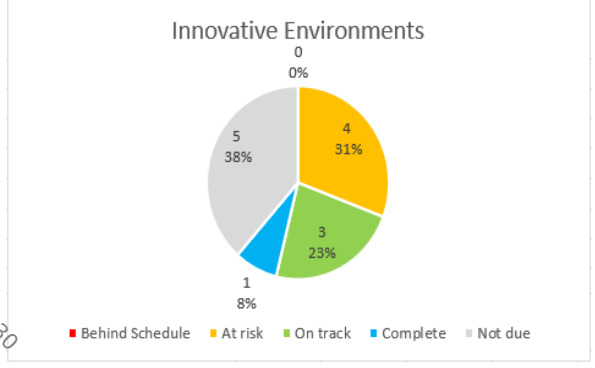


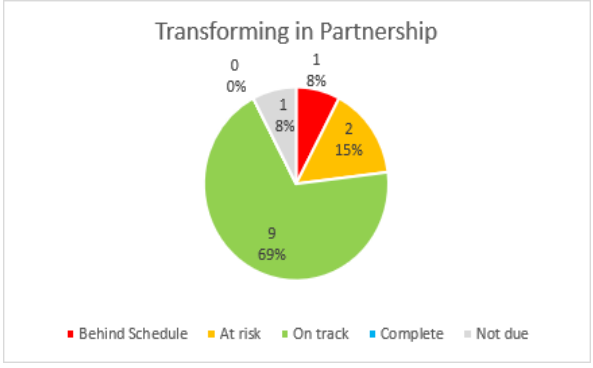


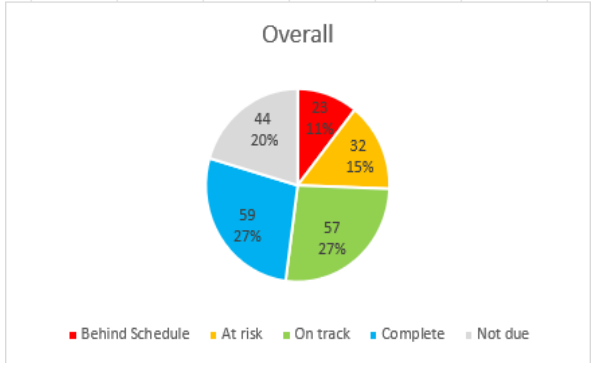












Role:	Acronym
Chief Executive Officer	CEO
Deputy Chief Executive Officer	DCEO
Executive Director of Primary Care, Community and Mental Health	ED PCC&MH
Executive Director of Finance, Capital and Support Services	ED FC&SS
Executive Director of People and Culture	ED P&C
Executive Director of Public Health	ED PH
Executive Director of Nursing, Quality, Women and Family Health	ED NQW&FH
Executive Director of Allied Health Professions, Health Sciences and Digital	ED AHPHS&D
Executive Medical Director	EMD
Executive Director of Planning, Performance and Commissioning	ED PP&C
Director of Corporate Governance / Board Secretary	DCG
Director of Strategic Improvement and Transformation	DSI&T
Associate Director of Estates, Facilities and Support Services	ADEF&SS

Focus on Wellbeing

Strategic Priority 1: Develop a whole system prevention plan across the life course

Executive Lead – Executive Director of Public Health

Intended Outcome/ Impact

- A vision for a joined-up preventative approach is developed
- Conditions are being created that support people to maintain a healthy weight
- Work towards meeting national smoking cessation targets

Commentary on Progress in this Quarter:

- 1.2) Powys Healthy Weights Action Plan is being implemented. Since the launch in August, the Powys Breastfeeding Welcome Scheme now has 130 organisations signed up. Introduction to Solid Foods ('weaning') training has been updated and provided to staff, along with resources updated for parents. The Powys Gold Standard Healthy Snack Award has been developed and promoted to early years' settings, alongside the provision of training sessions and individualised support. 5 settings have achieved the award.
- 1.3) Smoking cessation work is focusing on building on earlier successes and embedding work, including providing individualised support to community pharmacy staff to build their confidence in delivering support to smokers; embedding referral pathways and Nicotine Replacement Therapy (NRT) protocols, including working with Midwifery to increase CO monitoring and referral rates of pregnant smokers. The range of services available are continuously promoted through a communication and engagement plan, which has included the launch and extensive distribution of a regular Powys Smokefree newsletter. Q1 data showed 1.54% of smokers made a quit attempt through smoking cessation services, therefore on track to achieve 5% target by year end.

Commentary on red rated actions: N/A

Progress against key actions and milestones

Key Areas of Delivery	*Key Deliverables*	*Lead Executive*	*Status*				*Year End Delivery Confidence Assessment* *0 = Original*			
			Q1	**Q2**	**Q3**	**Q4**	**0**	**Q1**	**Q2**	**Q3**

Work with partners to develop a whole system approach to address common modifiable risk factors	1.1) Framework for whole system approach developed Q4	ED PH					M	M	M	Medium
Delivery of health board-led population level health improvement programmes	1.2) Implement the Powys Whole System Approach to Healthy Weights action plan, working in partnership Q1-Q4		Green	Green	Green		H	H	H	High
	1.3) Improve awareness of and access to NHS Stop Smoking services Q1-Q4		Green	Green	Green		H	H	H	High

Formal change request (Please tick as applicable and provide explanation below)			
Change in Scope	N/A	**Change in Timescale**	N/A

Executive Director Sign Off	Mererid Bowley (Executive Director of Public Health)

Strategic Priority 2: Deliver a Health Protection response, including vaccination

Executive Lead – Executive Director of Public Health

Intended Outcome/ Impact

- PTHB is able to provide a local health protection response that aligns with the Communicable Disease Outbreak Plan for Wales
- Eligible Powys population is offered vaccination, narrowing the uptake in inequities between groups
- Screening uptake rates are above targets

Commentary on Progress in this Quarter:

- 2.1) Emergency preparedness exercises undertaken: major incident response operational walkthroughs across hospital sites; Mpox walkthrough in two MIUs.
- 2.1) The Health Board responded to WAST 'major incident declared' notification for the Talerddig train collision on 21st October 2024.
- 2.2) Health Protection – responding to acute incidents and managing incidents and outbreaks to prevent spread and control spread of infections.

- 2.3) Vaccination programmes are planned and being delivered in line with national directives/guidance. Uptake continuously monitored to guide mitigating actions. For influenza, engagement occurring with GPs to encourage further vaccination sessions; Public Health Wales led communication campaign is supported by local communications team through health board channels, amplified through local networks. Covid-19 2024 autumn booster started 1st October; to improve access, more local clinics were scheduled using community hospitals; also hybrid approach adopted with support provided for booking and call handling by Vaccination Team to GP practices to deliver vaccination clinics.

Commentary on red rated actions: N/A

Progress against key actions and milestones

Key Areas of Delivery	*Key Deliverables*	*Lead Executive*	*BRAG ('not due' already greyed out)*				*Year End Delivery Confidence Assessment 0 = Original*			
			Q1	**Q2**	**Q3**	**Q4**	**0**	**Q1**	**Q2**	**Q3**
Ensure PTHB emergency preparedness and organisation resilience and compliance against Civil Contingencies Act	2.1) Review of civil contingency response plans. Implement required actions, including participation in training and exercises Q1-Q4	ED PH	Green	Green	Green		H	H	H	High
Provide Health Protection response to all hazards in line with Communicable Disease Outbreak Plan for Wales	2.2) Continue transition to a regional health protection service to enable a local response to health protection threats and contribute to Health Protection, Framework, in partnership with Powys County Council and Public Health Wales Q3				Amber		M	M	M	Medium
Implement respiratory vaccination programme in line with Welsh Government directives	2.3) Plan and deliver respiratory vaccination programmes Q1, Q3,Q4		Green		Green		H	M	H	High
Implement immunisation schedule in line with National Immunisation Framework and Welsh Health Circulars	2.4) Plan and deliver vaccination programmes Q4						H	M	M	High

Promote uptake of national screening programmes in partnership with Public Health Wales	2.5) Analyse data published and develop and implement action plan Q4						H	H	H	High

Formal change request (Please tick as applicable and provide explanation below)			
Change in Scope	N/A	**Change in Timescale**	N/A

Executive Director Sign Off	Mererid Bowley (Executive Director of Public Health)

Early Help and Support

Strategic Priority 3: Improve Access to Primary and Community Care

Executive Leads - Executive Director of Primary Care, Community and Mental Health / Executive Medical Director /Executive Director of Nursing, Quality, Women and Family Health

Intended Outcome/ Impact

- Improved outcomes through earlier, targeted interventions for those in need of support
- Quality, timely services provided closer to home
- Resilient and sustainable rural primary and community care services that meet the needs of the Powys population

Commentary on Progress in this Quarter:

Accelerated Cluster Development

- 3.1) Significant progress on collaborative and cluster engagement during Q3 has been achieved.
- 3.2) IMTPs agreed by Clusters, tabled for (Regional Partnership Board Executive) January 2025 for sign-off.
- 3.2) New meeting structure and procedures agreed to be implemented for Q4 onwards by the wider Cluster Team.
- 3.2) Initial Pan-Powys meeting arranged for January 2025 to reach agreement on new operational processes and address 25/26 priorities

General Medical Services

- 3.7) Primary & Community Care Academy continues to mature with multiple training support offers to all Primary Care Independent Contractors.
- GMS Unified Contract Assurance Framework process implemented Q3 for achievement Q4 2024/2025.
- 3.8) Termination of contract for Rhayader Medical Practice in the Mid Powys Cluster is due June 2025 – panel has convened with recommendation on next action to be discussed by Executive Team on 15th January 2025 and ratified by Board on 29th January 2025.
- 3.8) Sustainability review is complete, with individual conversations and support occurring with Practices where required.

Optometry

- 3.18) Launch of an occupational health service
- 3.19) Progress has been made on implementation of new aspects of Welsh General Ophthalmic Services (WGOS), including the embedding of WGOS 5 (Independent Prescribing)
- 3.19) Development of Welsh General Ophthalmic Services (WGOS) 4 pathways - WGOS 4 glaucoma filtering pathway was developed in Q3 and due to go live in Q4.

Community Pharmacy

- 3.30) The health board’s Medicines Management Team routinely monitors the provision of Clinical Community Pharmacy Service (CCPS) and “additional pharmacy services”. A contract assurance framework is in place to monitor service provision and the level of activity provided by each contractor.
- 3.32) Further work is required to engage with contractors to support the review of rota services to ensure that they are bringing the intended benefit to our population. Opportunities to remodel rota services to improve access to pharmacy services during the out of hours period will be explored.
- 3.33) The issues relating to 56-day prescribing are unique to Powys and require changes to the dispensing doctors contract – this is why it has been a challenge to progress this action.
- 3.34) Datix reports are actively monitored by the Medicines Management Team. Where the quality of reporting needs to be improved, the team collaborates directly with the contractor. Work is also being undertaken with contractors who are failing to submit Datix reports.
- 3.35) Work continues to encourage and support community pharmacy contractors to train as independent prescribers and to use their qualification and expand their scope of practice once qualified.

Women & Children

- 3.37) Digital Maternity Cymru national procurement process has ended with no system identified, the HB will submit a business case to WG during Q4, implementation is anticipated by end of 2025/26.
- 3.41) Community Paediatrics and Neurodevelopmental (ND) Services are a key priority, ND services is in escalation L3 in line with Health Board policy, an Executive Oversight Group is in place to monitor compliance and improvement. Significant quality improvement and transformation is required along with demand and capacity activity are being addressed to inform a business case and workforce modelling.
- 3.41) The action Develop an Additional Learning Needs Strategy for Powys including partnership delivery plan Q1-4 is green and completed.

Commentary on red rated actions: (from Q2)

Accelerated Cluster Development

- 3.4) Professional Nursing Collaborative: Some discussions underway, however progress expected to improve Q4.

Optometry

- 3.14) Pre-registration Optometrist between primary and secondary care in Cluster(s) Q2 has been delayed. Scope of role being considered by newly appointed Optometry Advisor.

Progress against key actions and milestones

Key Areas of Delivery	*Key Deliverables*	*Lead Executive*	*BRAG ('not due' already greyed out)*				*Year End Delivery Confidence Assessment 0 = Original*			
			Q1	Q2	Q3	Q4	0	Q1	Q2	Q3
Accelerated Cluster Development	3.1) Collaborative engagement and develop maturity Q1-Q4	ED PCC&MH	Amber	Amber	Green		H	M	M	High
	3.2) Continue to develop reporting and governance arrangements with RPB Executive (Pan Cluster Planning Group) Q3				Amber		H	H	H	Medium
	3.3) Implementation of Dental Collaborative (pending national negotiation outcome) Q2			Amber	Amber		M	M	L	Low
	3.4) Develop the Professional Nursing Collaborative Q2			Red	Amber		H	H	M	Medium
	3.5) Develop the Optometry Collaborative Q1		Green	Blue	Blue		H	H	M	High
	3.6) Continue to identify services best delivered at cluster or pan-cluster level Q4						H	H	H	High
General Medical Services	3.7) Annual Programme of Primary and Community Care Academy – training and support for all contractors; identifying funding opportunities; support for GMS (General Medical Services) PLT (Protected Learning Time); evaluation Q1		Green	Blue	Blue		H	H	H	High

	3.8) GMS Practice Sustainability analysis, review, and action planning Q2			Green	Blue		H	H	H	High
	3.9) Engagement with patients and stakeholders on perception and experience of access Q4						H	H	H	Low
	3.10) Development of workforce model in line with Strategic Programme for Primary Care/ Primary Care Strategic Workforce Plan & PTHB Frailty and Community Model Q3				Green		H	H	H	Medium
	3.11) Roll out multi-professional workforce tool Q3				Amber		M	M	M	Medium
Optometry	3.12) Systematic tracking of core hour provision Q2			Green	Blue		H	H	H	High
	3.13) Support and track access in relation to IPOS (Independent Prescribing Optometrists) Q1		Green	Green	Green		H	H	H	High
	3.14) Pre-registration Optometrist between primary and secondary care in Cluster(s) Q2			Red	Red		M	M	M	Low
	3.15) Establish inter-practice referral for urgent cases Q1		Blue	Blue	Blue		M	H	H	High
	3.16) School vision and eyecare access improvements Q2			Red	Red		L	L	L	Low
	3.17) Scope Special School Primary Care Eyecare Q1		Red	Red	Red		L	L	L	Low
	3.18) Publicise occupational health services offer Q1		Red	Blue	Blue		M	H	H	High
	3.19) Implement pathways with outreach Ophthalmology Services, clusters and Optometry practices for Glaucoma and Medical Retina pathways Q1-Q2		Amber	Green	Green		M	M	M	Medium
Dental	3.20) Maintain urgent access in General and Community Dental Service to balance of demand and capacity Q1	ED PCC&MH	Green	Green	Green		H	H	H	High
	3.21) Increase capacity of Llandrindod Wells contract Q2			Blue	Blue		H	M	H	Medium
	3.22) Secure future dental access in Newtown Q2			Green	Green		M	L	H	High

	3.23) Rural enhancement offer for Foundation Dentists Q4						L	L	L	Medium
	3.24) Continue to transfer patients from the dental waiting list to salaried General Dental Practitioner (GDP) in line with contract reform Q1		Blue	Blue	Blue		H	H	H	High
	3.25) Undertake dental waiting list cleansing to support accurate waiting list numbers Q1		Green	Blue	Blue		H	H	H	High
	3.26) Recruit additional dental officer for sedation by end of Year 1 Q4						M	M	M	Low
	3.27) Rescope mobile dental services in areas with limited or no access Q1		Blue	Blue	Blue		H	H	H	High
	3.28) Develop undergraduate dental therapy placement programme with Cardiff Dental School Q4						M	M	M	Low
Community Pharmacy	3.29) Further development of Assurance Framework; Annual programme of contract monitoring – and targeted visits (50% of pharmacies in Year 1); implement contract breach process by year end Q4	EMD					H	H	H	High
	3.30) Ensure access and monitor provision of Clinical Community Pharmacy Service (CCPS) and “additional pharmacy services”. Q1-Q4 Ongoing (monthly)		Green	Green	Green		H	H	H	High
	3.31) Review and update of service specifications for locally commissioned services Q4						H	H	H	High
	3.32) Review pharmacy ‘rota services’ to ensure that they are delivering value to our population Q4						H	M	M	Low
	3.33) Work with Welsh Government to address challenges that are unique to Powys (e.g. implementation of 56-day prescribing in dispensing practices) Q4						L	L	L	Low
	3.34) Work with contractors to improve the quality of Datix reporting and ensure that learning is shared as appropriate Q1-Q4 Ongoing		Green	Green	Green		H	H	H	High

	3.35) Continue to encourage Pharmacists to train as independent pharmacist prescriber (IPPs) and monitor provision of IPP services across Powys Q1-Q4 Ongoing		Green	Green	Green		H	H	H	High
Women & Children's - Maternity	3.36) Delivery of the Maternity Assurance and Safety Improvement Plan Q1-4		Blue	Blue	Blue		H	H	H	High
	3.37) Implementation of Digital Maternity Cymru (DMC) appropriate to PTHB Q1-4		Amber	Amber	Amber		M	M	M	Medium
	3.38) Review workforce and implement the revised workforce review Q1-4		Green	Green	Amber		H	M	M	Medium
	3.39) Implementation of Health Inspectorate Wales recommendations including birth centre environments Q1-4		Green	Green	Green		M	L	L	Low
Women & Children's – Women's Health	3.40) Assessment and local delivery of All Wales policy and plan requirements, adapted to PTHB context Implement plans for Women's Health and Sexual Health Improvement; HIV and All Wales Women's Health Implementation Group Priorities Q1-4	ED NQW&FH	Green	Green	Green		M	M	M	Medium
Women & Children's – Pathway Development	3.41) Implementation of key service / pathway developments: - Develop and deliver Community Paediatric Remodel action plan - Implementation of the multi agency Neurodevelopment Strategic Action Plan for Powys - Develop an Additional Learning Needs Strategy for Powys including partnership delivery plan Q1-4		Amber	Amber	Amber		M	H	H	High

Formal change request (Please tick as applicable and provide explanation below)			
Change in Scope	X	**Change in Timescale**	X
Change in Scope and Timescale			

• 3.17 - Special School Primary Care Eyecare (SPEC) is dependent upon national clinical pathways, led by national clinical leads and has been assigned lower priority versus other clinical pathways. Scope of service has not been communicated to HBs so cannot progress this action. No indication this pathway is imminent during 24/25 – request to remove as a key deliverable for 24/25	
Executive Director Sign Off	Elaine Lorton (Executive Director of Primary Care, Community and Mental Health) Kate Wright (Executive Medical Director) Claire Roche (Executive Director of Nursing, Quality, Women and Family Health)

Strategic Priority 4 - Design and Deliver a phased Frailty and Community Model

Executive Lead - Director of Strategic Improvement and Transformation

Intended Outcome/ Impact

- A sustainable approach to frailty and community care, improving equity of access
- Risk stratification of the population to deliver effective support for those with greatest need and at greatest risk of ill health
- Joined up support for physical and cognitive frailty and improved co-ordination at end of life particularly the last year of life
- Associated reduction in emergency admissions/ prevention of avoidable deterioration in health such as deconditioning and fractures

Commentary on Progress in this Quarter:

- 4.1) Continuous Engagement in sharing the challenge and understanding Discovery findings; shaping and refining ideas Q1-4: Building on the previous joint Better Together / Sustainable Powys sessions back in February and March 2024, further joint sessions between PTHB and Powys County Council have taken place in Q3 with Town and Community Councillors. For PTHB, these sessions have outlined the early case for change as well as recent transformation work. The final session was postponed due to the weather and will take place in Q4.
- 4.2) Next phase of design including configuration of tiered community model, outpatient, daycase and admitted patient care Q2-3: Work through the new Better Together Portfolio has taken place to develop scenarios for the next phase of design of the tiered community model. This work has included a desktop site review to help inform the clinical strategy. Workshops are scheduled for January 2025 covering Mental Health, Diagnostics and Planned Care, and Frailty and Community Model including Urgent Care, which will support the design phase, as well as the priorities for the next year of the PTHB Integrated Plan. The workshops are taking place in Q4 hence an Amber rating.
- 4.3) Identification of service development Q3: Work has taken place to identify potential areas for service development. In a similar way to 4.2 above, this action has been marked Amber as the confirmation of these areas will come from the workshop sessions planned for January 2025.

- 4.4) Minimum 12 Week Consultation for areas of significant service change Q3-4: Work is underway to confirm the consultation timescales and process.
- 4.5) Develop Frailty scoring Q1-Q3: Frailty scoring has been developed across primary and community care in Powys, with the Rockwood Frailty scoring built into various assessment documents. Work will continue to embed the approach and to digitally collate frailty scoring data consistently for Powys patients.
- 4.6) Develop the approach to Comprehensive Geriatric Assessment and care planning Q1-Q3: The Comprehensive Geriatric Assessment process in Powys has been developed and is now being delivered by several services across primary and community care in Powys. The revised approach to Treatment Escalation, in line with agreement by national colleagues to pilot this in the community, has been rolled out, with training provided to staff in primary and community care. Work will continue to embed the approach for Comprehensive Geriatric Assessment and to care planning for people living with frailty.
- 4.7) Review access to Fracture Liaison Service Q3-Q4: Task & Finish Group in place which has reviewed access and identified inequity for Powys patients. Early indications show potential improvements in patient outcomes, experience and cost through ensuring better access to Fracture Liaison Services for Powys patients. A business case, including different options, has been drafted and will be finalised in Q4. Conversations with national colleagues have taken place around potential funding to support the Powys business case.
- 4.8) Implement National Community Nursing Framework in Powys Q1-Q4: Following a self-assessment against elements of the Community Nursing Standards in Q2, an action plan is in place to prioritise the areas where further development is needed, recognising what can be delivered in a rural county. Further Faster funding from Welsh Government has enabled the successful recruitment to a dedicated End of Life Care Planning Facilitator role which will enable and empower health and social care staff, including voluntary sector staff, to deliver best practice in end of life care.
- 4.11) Subject to approval, support the National Cellulitis Improvement Programme with a Powys-related post Q1-Q3: Following agreement of the Service Level Agreement between the health board and the National Lymphoedema Service, an individual has been seconded into the Powys-funded post in the national team and started on 01/11/2024. Other clinical staff within the national team can provide cross-cover as needed.
- 4.12) Scope phase 1 Urinary Tract Infection (UTI) pathway transformation and commence implementation Q2–Q3: A Task & Finish Group was established and identified that training opportunities around UTI prevention and management were not being taken up by all relevant staff – this is being addressed to improve the quality of care provided and includes face to face training provided by the PTHB Continence Service, as well as e-learning. A list of various UTI related literature and resources was collated to be available in one single place. Posters to provide guidance about UTI management and prevention have been printed and are being distributed to GP practices, community pharmacies, care homes, day centres, PTHB sites and PTHB community teams. Posters about hydration and dehydration have been printed but will be disseminated in the Spring / Summer to coincide with warmer weather.

Commentary on red rated actions:

- 4.10) Commence implementation including liaison with out of county providers (to improve coordination of the Last Year of Life) Q3-Q4: Following the approval by national colleagues to implement a revised Treatment Escalation process in the community in Powys, work has focused on the development of the new process, including training for staff to ensure they are aware of and working to the new process. This has meant that the liaison with out of county providers has not taken place in Q3 and the next steps for this work will be confirmed through the Frailty & Community Model Programme Board.

Progress against key actions and milestones

Key Areas of Delivery	*Key Deliverables*	*Lead Executive*	*BRAG ('not due' already greyed out)*				*Year End Delivery Confidence Assessment* *0 = Original*			
			Q1	**Q2**	**Q3**	**Q4**	**0**	**Q1**	**Q2**	**Q3**
Continue development of tiered community model	4.1) Continuous Engagement in sharing the challenge and understanding Discovery findings; shaping and refining ideas Q1-4	DSI&T	Green	Green	Green		H	H	H	High
	4.2) Next phase of design including configuration of tiered community model, outpatient, daycase and admitted patient care Q2-3			Green	Amber		M	M	H	High
	4.3) Identification of service development Q3				Amber		M	M	M	High
	4.4) Minimum 12 Week Consultation for areas of significant service change Q3-4				Green		M	M	M	Medium
Continue to implement Frailty Model, including optimisation and join up for frailty of memory	4.5) Develop Frailty scoring Q1-Q3		Green	Amber	Blue		M	M	M	Medium
	4.6) Develop the approach to Comprehensive Geriatric Assessment and care planning Q1-Q3		Green	Green	Blue		M	M	M	Medium
	4.7) Review access to Fracture Liaison Service Q3-Q4				Green		H	H	H	High
	4.8) Implement National Community Nursing Framework in Powys Q1-Q4		Green	Green	Amber		M	M	M	Medium
Improve coordination of the Last Year of Life	4.9) Finalise approach to planning for the Last Year of Life with major conditions Q1-Q2		Green	Blue	Blue		H	H	H	High
	4.10) Commence implementation including liaison with out of county providers Q3-Q4				Red		M	M	M	Low
Review and refine the Community Hospital model	~~Scope an improved approach to cognitive impairment on general wards Q1-Q2~~ see change in box below		Green	Red			M	M	L	Select

	~~Pilot the approach Q3-Q4~~						M	M	L	Select
Support Admission Avoidance	4.11) Subject to approval, support the National Cellulitis Improvement Programme with a Powys-related post Q1-Q3		Green	Green	Blue		H	H	H	High
	4.12) Scope phase 1 Urinary Tract Infection (UTI) pathway transformation and commence implementation Q2–Q3			Green	Blue		H	H	H	High
	4.13) Review the impact of the PTHB-element of the National Cellulitis Improvement Programme Q4						H	H	H	High

Formal change request (Please tick as applicable and provide explanation below)

Change in Scope	N/A	**Change in Timescale**	X

Change in Timescale

- Review and refine the community hospital model – due to the Temporary Service Change to co-locate patients this area of delivery has been reprioritised.

Executive Director Sign Off	Lucie Cornish (Director of Strategic Improvement and Transformation)

Strategic Priority 5 - Deliver the Planned Care & Diagnostics Programme

Executive Leads – Executive Director of Primary Care, Community and Mental Health / Executive Director of Planning, Performance and Commissioning / Executive Director of Allied Health Professions, Health Sciences and Digital

Intended Outcome/ Impact

- As many patients treated in Powys as possible – delivery of Rural Regional Centres and North Powys Wellbeing Programme
- Improved resilience of provider services and greater utilisation of provider services capacity/ system assets
- Getting It Right First Time is the default method of operation with associated improvements in quality, governance and assurance

Commentary on Progress in this Quarter:

- 5.20 / 5.21) **POCT –** There was a delay in making the POCT post permanent, however this has now been recruited to and we will continue to work towards targets and goals.
- 5.1) **GIRFT**: The GIRFT implement support sessions are complete for Ophthalmology, Orthopaedics, General Surgery, Gynaecology and Urology. Improvement requirements are continuing and will be performance assured through the Clinical Implementation Networks (CIN). The number of CIN meetings and PTHB representation is currently under review.
- 5.4) **Key Strategic Relationships &** 5.8 / 5.9) **Referral Management Solutions:** The Musculoskeletal (MSK) business case has been approved through IBG and Executive Committee. Business case implementation being progressed to include the implementation of the MSK clinical review and triage, speciality leadership sessions for Orthopaedics and a joint appointment of an Orthopaedic Consultant post for Uppers, recruitment is underway and will be complete in Q4. Dermatology**:** The North Powys Advice and guidance non-USC lesion is 3 months into a 6-month pilot. A paper is in draft to highlight data from the pilot so far and discuss next steps in implementation for Dermatology advice and guidance pathways for Mid and South Powys. Referral Management Solution for Dentistry was approved to be paused during Q2.
- 5.13) **Improve value in key specialities**: Work is underway for a North Powys Eyecare Pathway to focus on opportunities for a nurse led Wet AMD Service as well as establishing a Hydroxychloroquine (HCQ) Retinopathy Service. Work will continue into Q4 to implement nurse led Wet AMD Service in North Powys following scoping exercise and draft business case as well as complete the HCQ project.
- 5.15) **Outpatient Transformation**: Implementation of outpatient transformation plan is progressing well to include increased access to virtual appointments, access to advice and guidance, modernisation of follow ups including see on symptom. During Q4 there will be continued implementation of outpatient transformation plan to include virtual appointments, access to advice and guidance, modernisation of follow ups including see on symptom. This will be supported by the 3Ps Waiting Well Service, a Clinical Lead is in post and during Q2 the Single Point of Access is being established prioritising Ophthalmology.
- 5.20) **POCT**: Business Case has been approved by the health boards Investment Benefits Group to present the case for a permanent Point of Care Testing (POCT) resource in Powys Teaching Health Board (PTHB). POCT Manager is working in alignment to deliver (All Wales Point of Care Testing) WPOCT system, associated expectations on Health Boards, and the resource required for implementation and long-term management of the system
- 5.18) **Radiology Provision across Powys (RISP):** Phase 1 of the X-ray equipment replacement to allow the implementation of RISP is on schedule to complete in January in Llandrindod Wells, Welshpool and Ystradgynlais. Phase 2 of the X-ray equipment replacement will commence in January 2025 which is on course to complete by March 2025.

Commentary on red rated actions:

- 5.2) **Seek Consultant Urologist sessions:** PTHB were unsuccessful in the Planned Care Transformation fund for speciality consultant sessions resulting in PTHB not being able to progress with Consultant Urologist sessions at present. A further review and plan will be developed for the 2025/26 plan.
- 5.11) **Dental**: The proposal to purchase high quality cameras to allow good clinical photography in Dental service is currently paused until the outcome and evaluation is complete for the Dermatology pilot. This was a decision of the board due to the amount of funding that would be required. If the Dermatology project is successful, the evidence would be used to progress the Dental bid. (Relating to Q2)

Progress against key actions and milestones

Key Areas of Delivery	*Key Deliverables*	*Lead Executive*	*BRAG ('not due' already greyed out)*				*Year End Delivery Confidence Assessment 0 = Original*			
			Q1	**Q2**	**Q3**	**Q4**	**0**	**Q1**	**Q2**	**Q3**
GIRFT Recommendations	5.1) Continue implementation of GIRFT recommendations for General Surgery, Orthopaedics and Ophthalmology to include repatriation of low complexity day cases Q1-Q4	ED PCC&MH ED PP&C	Green	Green	Green		H	H	H	High
	5.2) Seek Consultant Urologist sessions to scope community urology service Q2-Q4			Red	Red		M	L	L	Low
Key Strategic Relationships	5.3) Explore Opportunities for jointly funded or regional post Q1		Blue	Blue	Blue		H	H	H	High
	5.4) Recruitment for jointly funded or regional post Q3				Amber		H	M	M	High
	5.5) Evaluation of jointly funded or regional post Q4						H	M	M	Medium
Referral Management Solutions	5.6) Scope a (Provider) interface triage pilot for Orthopaedic Referrals Q1		Blue	Blue	Blue		H	H	H	High
	5.7) Pilot interface triage solution for Orthopaedic Referrals Q2			Blue	Blue		H	H	H	High
	5.8) Evaluate interface triage solution for Orthopaedic Referrals and any associated Business Case through the Investment Benefit Group Q3				Blue		H	H	H	High
	5.9) Subject to approval implementation of interface triage solution for Orthopaedic Referrals; Evaluation Q3-Q4				Green		H	H	H	High

	5.10) Scope a referral management solution for Dermatology; Pilot subject to any associated Business Case support; Evaluate; begin phased roll-out Q1		Blue	Blue	Blue		H	H	H	High
	5.11) Develop referral management solution for dentistry in relation to oral cancer Q2			Red	Red		H	M	L	Low
	~~5.12) Further develop phlebotomy service Q3-Q4~~ Year 2						M	M	M	Select
Improve Value in Key Specialities	5.13) Continued implementation of Wet Age-Related Macular Degeneration (AMD) and Cataracts improvement plan in alignment with GIRFT Q1-Q4	ED PCC&MH ED PP&C	Green	Green	Green		H	H	H	High
Implement the Outpatient Transformation Plan	5.14) Appoint permanent Assistant Medical Director for Planned Care Q1		Blue	Blue	Blue		M	H	H	High
	5.15) Continued implementation of outpatient transformation plan (virtual appointments, access to advice and guidance, modernisation of follow ups including see on symptoms) Q1-Q4		Green	Green	Green		M	M	H	High
Radiology Provision across Powys (enabling implementation of RISP)	5.16) Submit capital business case for replacement of X-ray equipment to enable implementation of RISP Q1	ED AHPHS&D	Blue	Blue	Blue		M	H	H	High
	5.17) Review x–ray provision across Powys as part of work on sustainable model Q1		Blue	Blue	Blue		H	H	H	High
	5.18) Develop x-ray implementation plan and implement phase 1 Q2-Q4			Green	Green		M	L	H	High
Enhance the provision of Point of Care Testing throughout Powys	5.19) Review and develop existing POCT provision and governance: Establish QA Compliance framework, analyse asset registry, monitoring initiation and training development Q1-Q2	ED PCC&MH ED PP&C	Green	Blue	Blue		H	H	H	High

	5.20) Expand availability of POCT provision in support of clinical pathway development and governance: identify opportunities in primary & community care, prepare for internal audit Q3-Q4				Amber		M	M	M	Medium
	5.21) Identify ongoing funding for the POCT Co-ordinator role Q3-Q4				Blue		M	M	M	High

Formal change request (Please tick as applicable and provide explanation below)			
Change in Scope	N/A	**Change in Timescale**	X

Change in Timescale

Phlebotomy – This was identified for Year 2 and should not sit in this delivery plan, suggest this is removed.

Executive Director Sign Off	Elaine Lorton (Executive Director of Primary Care, Community and Mental Health) Nicola Johnson (Executive Director of Planning, Performance and Commissioning) Claire Madsen (Executive Director of Allied Health Professions, Health Sciences and Digital)

Tackling the Big Four

Strategic Priority 6 - Develop and Deliver a Major Conditions Plan

Executive Leads - Director of Strategic Improvement and Transformation / Executive Medical Director / Executive Director of Allied Health Professions, Health Sciences and Digital / Executive Director of Planning, Performance and Commissioning / Executive Director of Primary Care, Community and Mental Health

Intended Outcome/ Impact

- A shift to prevention to improve population health and reduce the burden of ill health, with smarter approaches to segment and target those at risk
- Optimising the key pathways of care to improve equity of access and patient experience
- Joined up care across physical and mental health; effective management of long term conditions and a core approach to rehabilitation
- Greater co-ordination of care to improved efficiency, performance and outcomes

Commentary on Progress in this Quarter:

- 6.2) Map and develop key optimal pathways for Diabetes: A copy of the national diabetes atlas for 2022/23 has been shared with PTHB in which a deep dive into the data has highlighted variation across pathway components with sub-optimal adherence. Wider work has included modelling to include insulin pump reviews for targeted patients and wider scope against co-morbidities within high-cost user data. Executive lead identified for progression of this work and next steps will be to identify a clinical lead and wrap around project plan.
- 6.3) National prescribing indicators for primary care relating to AF (AF patients with a score of 2 or more on anticoagulant drug therapy): Q3 data is not yet available, however performance against this indicator declined in Q1 (92.4%) and again in Q2 (91.6%). Based on Q2 2024/25 data, PTHB is the second worst performing health board against this indicator (range = 90.4%-95.6%). There isn't a specific target for this indicator, although we would not expect our performance to be declining. Further work is required to understand why this is the case.

Commentary on red rated actions:

- 6.1) Development of a phased major conditions transformation plan: An Executive Lead was agreed in January 2025. An SRO has yet to be identified for the work programme and remains red in reporting. Progress has however been made in the background with focus on High-cost user data modelling which has identified co-morbidities as an area of higher spend based on patients with more than one condition. Quarter 4 will define the priority for this to continue into 2025/2026.
- 6.9) Single Cancer Pathway – Review has been completed but there remains performance issues across commissioned services as reported through the IQPR.

Progress against key actions and milestones

Key Areas of Delivery	*Key Deliverables*	*Lead Executive*	*BRAG ('not due' already greyed out)*				*Year End Delivery Confidence Assessment* *0 = Original*			
			Q1	**Q2**	**Q3**	**Q4**	**0**	**Q1**	**Q2**	**Q3**
Development of a transformative Major Conditions Plan	6.1) <u>Development of a phased major conditions transformation plan</u> to develop: a less siloed approach; streamline appointments, diagnostics, assessments, care and treatment plans, reviews and polypharmacy; and to improve co-ordination in the last year of life Q1- Q3 development of the plan	DSI&T	Amber	Red	Red		H	H	L	Low

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Optimal Pathways	6.2) Map and develop key optimal pathways for Diabetes (in liaison with national Value and Sustainability Work) Q2 confirm baseline and gap analysis Q3-Q4 first phase improvement			Amber	Amber		M	M	L	Low
Stroke	6.3) Review National Prescribing indicators in primary care for Atrial Fibrillation; explore improvements Q3	ED PP&C EMD			Amber		H		H	Medium
	6.4) PTHB Clinical engagement in key Strategic Programmes for Stroke (Wales and England particularly Herefordshire & Worcestershire) Q3	DPPP&C EMD			Green				H	High
	6.5) Incorporation of guidelines for stroke rehabilitation Q3	ED AHPHS&D			Green				H	High
Diabetes	6.6) Delivery of All Wales Diabetes Prevention Programme (AWDPP) Q1-Q4	DSI&T ED PH	Select	Select	Green		H			High
Cardiac	6.7) Community cardiology Q4	ED PCC&MH / ED PP&C					H		M	Select
Cancer Cancer Improvement Plan	6.8) Deliver the PTHB Cancer Improvement Plan Q1- Q4	EMD	Green	Amber	Amber		M	M	M	Medium
Single Cancer Pathway	6.9) Review variation of Single Cancer Pathway performance across secondary care providers and reduction of backlog of those waiting over 62 days for first definitive cancer treatment Q1 – Q4	EMD	Red	Red	Red		L	L	L	Low
Implement Improving Cancer Journey	6.10) Implement Improving Cancer Journey Programme Phase 2 Q1-Q4	EMD	Green	Green	Green		H	H	H	High

	6.11) Annual review of PTHB Cancer Improvement Plan and update for 2024-25 at year end Q4						H	H	H	High
Respiratory Ensure equitable and standardised MDT services across the whole of PTHB	6.12) Continue to explore options for medical cover across PTHB Q1-Q3	ED PCC&MH	Amber	Amber	Amber		M			Medium
	6.13) Provide support to Primary Care to implement Asthma plans for the asthma population Q2-Q4			Green	Green		M	M	M	Medium

Formal change request (Please tick as applicable and provide explanation below)			
Change in Scope	N/A	**Change in Timescale**	N/A

Q3 Change in Executive Lead

6.2) Map and develop key optimal pathways for Diabetes – Change request to remove DSI&T and transfer to ED PCC&MH.

6.6) Delivery of All Wales Diabetes Prevention Programme (AWDPP) Q1-Q4 – Change request to remove DSI&T as Exec Lead.

Executive Director Sign Off	Lucie Cornish (Director of Strategic Improvement and Transformation) Kate Wright (Executive Medical Director) Claire Madsen (Executive Director of Allied Health Professions, Health Sciences and Digital) Nicola Johnson (Executive Director of Planning, Performance and Commissioning) Elaine Lorton (Executive Director of Primary Care, Community and Mental Health)

Tackling the Big Four

Strategic Priority 7 - Deliver the Mental Health Transformation Programme

Executive Lead – Executive Director of Primary Care, Community and Mental Health

Intended Outcome/ Impact

- Delivery of equitable and quality mental health care that meets the needs of the population
- Increased efficiency and integration of services to improve sustainability and user experience with clear navigation, access and referral
- Improved co-ordination and care planning with reduction in avoidable urgent and emergency attendances and out of county care

Commentary on Progress in this Quarter:

- 7.3) **Transformation of Adult and Community Model Phase 1 (includes alignment of Duty and Assessment Model):** This work previously involved urgent temporary service change work for remodelling Mental Health inpatient provision for Powys. The analysis and case for change worked up for this project mandate was submitted to the Strategic Change Programme Board who agreed with the findings, that the case for change was not convincing, with a decision taken in Q3, to cease this temporary service change. Preliminary transformation work taking place with partners including North Powys Wellbeing Programme, Social Care and 3rd Sector colleagues to scope the redesign of the Mental Health community model for Powys, ensuring equitable, quality care, in line with national strategies, that meets the needs of the Powys population is continuing. This work has been identified as a priority for future MH IMTP. Following a North Powys Wellbeing joint workshop in November 2024, a follow-on workshop to further progress the Mental Health Community Model for Powys is planned for 17.1.25. The alignment of Powys Dementia Home Treatment Teams (DHTTs) to create a sustainable pan-Powys team, improving equity and consistency across Powys is progressing. A design workshop took place on 7/10/24 attended by the wider Mental Health team and medical staff, which resulted in a proposed pan-Powys DHTT pathway, which along with proposed staff model and draft working pattern is due to be submitted for sign off via Mental Health Senior management team. Following decision taken at The Mental Health Transformation workshop in April 2024, mental health baseline data has been reviewed, by the North Powys Wellbeing team, to reflect 2023/24, rather than 2022/23. This data provides increased reliability as a baseline, however has required further validation with external modelling consultant, causing slippage against original deadline. The 2023/24 baseline data has now been delivered and is being confirmed with Mental Health Service Leads. Demand/capacity modelling work was ongoing throughout Q3, conducted by the North Powys Wellbeing team. It is envisaged that this work will be further informed by workshops planned for January Q4, eg workshop to define the MH Community Model for Powys and further transformation programme workshop, allowing modelling to take place during Feb Q4.
- 7.7) **Expand capacity to extend single point of access including Next Phase of Development offer alignment with 111P2 for Duty and Assessment Model:** The Mental Health Single Point of Access (SPOA) phase 1 went live on 16/9/24. The SPOA includes a team conducting telephone-based triage for patients referred to the Mental Health service, using the validated national standard of the Colgate model, aligned with the 111(2) service and incorporating the previous referral administration hub. The teams are co-located at Bronllys hospital. SPOA outcome measures have been defined and a BI reporting dashboard established. A successful business case has been submitted to the Investment Benefits Group, with subsequent Executive Committee approval (8.1.25), which will provide ongoing funding for the service, allowing further refinement and embedding of phase 1 and development and implementation of phase 2, at pace. Phase 2 includes patient assessment close to 'the front door' and initial conversations are taking place with PTHB MH teams to work towards achieving a joint, 'trusted' assessment and with PCC colleagues about principles for social care involvement. A working group is in place to progress phase 2, which will begin with a joint workshop 21.1.25. Plans are also in place for a co-production group with service users to provide input to the assessment phase. Stakeholder communications are being managed via the Triage & Assessment Communications task & finish group, which includes input from PTHB Engagement & Communications team. Representatives of the Triage & Assessment transformation workstream are due to present an update about the MH SPOA and forthcoming phase 2 at the Pan-Powys Cluster meeting

13.02.2025. This will also include an update regarding forthcoming work to implement electronic referral for GPs using CCG system integration with Welsh Admin Portal (WAP), which is in discussion with the digital team for roll out of WAP to the MH SPOA. The 111(2) service contributes to reducing the demand on Emergency Departments, General Practitioners, the Police, the Welsh Ambulance Service NHS Trust and mental health crisis services. The inclusion of the 'Triage & Assessment' team is providing benefits of a streamlined referral pathway, leading from a single point of access for referral. This is increasing efficiency of receipt of referrals, ensuring assessment occurs close to the front door (phase 2), enabling efficient access to the service needed, reducing complexity of navigating referrals and any internal delay caused by multiple referrals/ assessments.

- 7.13 / 7.14) **Ensure access to provision of sanctuary for adults and children: Adults -** Discussion held at Executive Committee on 15th May 2024 regarding the preferred way forward for Sanctuary provision for Adults in Powys, given the difficulties faced in locating robust evidence for such provision in a highly rural area. PTHB Executive Committee confirmed they will support a pilot approach and asked for this to be scoped and taken back to Execs in due course. A paper went to the PTHB Executive Committee on 7th August 2024, (deferred from 10.7.24), and now requires further work to align with Mental Health whole system change work prioritised for inclusion in future IMTP. The preferred model is to pilot under the North Powys Wellbeing Programme, within Newtown, given the inequity of MH offer across the county and the particular needs in this geographical area.
- 7.11) **Children -** A CAMHS Crisis Hub is now fully operational, providing access to sanctuary for children in a safe, friendly, built for purpose environment. A new Rapid response & Outreach Team (RRO) has been recruited with working hours aligned to the adults CRHTs, enabling a greater OOH for CYP. The Hub uses an MDT approach to supporting young people and their families in mental health distress. Engagement with families is ongoing with young people supporting the ongoing development of the project. This facility is increasingly diverting children and young people from attending A&E, or acute mental health wards, whilst offering intensive home treatment and assertive outreach service. Numbers of appointments/ contacts are increasing month on month, with a 25% reduction in average monthly Welsh emergency department attendances (0-17yr olds), throughout 2024/25 from an average of 7.2 attendances per month in 2023/24 to 5.4 attendances per month in 2024/25 from April – August, (6 Goals for Urgent & Emergency Care 2021-2026). This successful project is yet to secure 2025/26 funding.
- 7.15 – 7.18) **Take forward the next phase of work to enable access to a step-down solution for those with complex needs:** The Project Initiation Document for this initiative was approved by the Transformation Board in February 2024. However, this project remains paused since 8th May 2024, initially due to the redeployment of the Transformation Manager to support the internal escalation programme within Mental Health & Learning Disability Services. Work was in place to convene a multi-agency options appraisal workshop, followed by a series of engagement events - these have been temporarily stepped down. This project is interlinked with transformation work around the MH Community Model and overall strategy and will require consideration of alignment with other workstreams, following confirmation of priority projects within Mental Health.
- 7.19) **Next phase of neurodiversity pathway development:** This deliverable is being led within the MH Learning Disabilities and Neurodiversity Teams. Powys is the first region in Wales to now have an ND pathway which includes a jointly operated Integrated Autism Service (IAS) working alongside a new ADHD service. New working practices are being embedded, with the pathway undergoing service evaluation and further development. Phase 2 for future IMTP is to develop into a sustainable service. Current specialist workforce is fragile due to small size and staffing comprised of temporary seconded posts.

Commentary on red rated actions:

- 7.12) **Develop access to provision for sanctuary for adults:** This programme has been suspended due to lack of evidence for rural areas. It is not a current priority for 2024/2025.
- 7.15 – 7.18) **Step-down solution:** This project was paused on 8th May 2024 and is not a current priority.

Progress against key actions and milestones

Key Areas of Delivery	*Key Deliverables*	*Lead Executive*	*BRAG ('not due' already greyed out)*				*Year End Delivery Confidence Assessment* *0 = Original*			
			Q1	Q2	Q3	Q4	0	Q1	Q2	Q3
Transformation of Adult and Community Model Phase 1 (includes alignment of Duty and Assessment Model)	7.1) Refining the baseline. Refining the modelling for the new model. Continuous engagement Q1	ED PCC&MH	Amber	Red	Red		H	M	M	High
	7.2) Public engagement and consultation Q2			Amber	Red		M	H	M	High
	7.3) Workforce design and further consultation Q3				Blue		M	M	M	High
	7.4) Phase 1 implementation Q4						M	M	M	High
Expand capacity to extend single point of access including Next Phase of Development offer alignment with 111P2 for Duty and Assessment Model	7.5) Scope model. Refine baseline including urgent referral information. Continuous engagement. Scope expansion of "front door" role including development to align other referral processes. Q1		Green	Blue	Blue		M	H	M	High
	7.6) Develop phased delivery plan Q2			Blue	Blue		M	H	H	High
	7.7) Phase 1 implementation including administrative single point of access Q3				Blue		M	M	H	High
	7.8) Phase 2 implementation including commencing development of referral routes for Secondary Care referrals Q4						M	M	H	High
Ensure access to provision for sanctuary for children	7.9) Engagement with children and young people, families, and carers	ED PCC&MH	Blue	Blue	Blue		H	H	H	High

	(i)Workforce design Q1									
	7.10) (ii) Recruitment Q2			Blue	Blue		M	H	H	High
	7.11) (iii) Implementation of rapid response and outreach service Q3-Q4				Green		M	H	H	Medium
Develop access to provision for sanctuary for adults	7.12) i) Through collaboration with stakeholders, staff and partners, design a sustainable model for a highly rural setting Q3-4				Red		M	M	M	Low
	7.13) (ii) Assess impact of right care, right person 7.14) Q3 Year 2 Phased Delivery Plan				Amber		H	H	H	High
Take forward the next phase of work to enable access to a step-down solution for those with complex needs	7.15) Continuous engagement Q1-Q4		Green	Red	Red		M	H	L	Low
	7.16) Explore and develop advisory options appraisal Q1		Red	Red	Red		L	L	L	Low
	7.17) Design and workforce planning Q2			Red	Red		M	L	L	Low
	7.18) Preparation for procurement Q3-Q4				Red		M	L	L	Low
Next phase of neurodiversity pathway development	7.19) A revised pathway for neurodiversity pathway Q1-Q4		Amber	Blue	Blue		H	L	M	High

Formal change request (Please tick as applicable and provide explanation below)

Change in Scope	N/A	**Change in Timescale**	X

Change in Timescale

- 7.12) **Develop access to provision for sanctuary for adults:** This programme has been suspended due to lack of evidence for rural areas. It is not a current priority for 2024/2025.
- 7.15 – 7.18) **Step-down solution:** This project was paused and is not a current priority.

Executive Director Sign Off	Elaine Lorton (Executive Director of Primary Care, Community and Mental Health)

Joined Up Care

Strategic Priority 8 – Improve pathways of care focused on system flow

Executive Lead - Executive Director of Primary Care, Community and Mental Health

Intended Outcome/ Impact

- People Home Fitter and Faster
- Co-ordinated and effective pathways of care which deliver an efficient flow across health and care systems
- Associated elimination of pathways of care delays and reduction in avoidable bed utilisation / average length of stay

Commentary on Progress in this Quarter:

- 8.3) Embed Digital Patient Flow System (DigiFLO) into standard practice and broaden user operability Q3: Powys DigiFLO is now live across Adelina Patti, Bryn Heulog, Claerwen, Epynt, Graham Davies, Llewellyn, Maldwyn, Twymyn and Y-Bannau wards, in addition to Glan Irfon. The Powys DigiFLO Information Roadshow commenced in November to provide training and guidance on utilisation and support the embedding into practice. 4 site visits took place throughout Q3, with the remaining site visits planned throughout Jan-Feb. Although system utilisation has increased, more work is needed to fully embed into standard practice, therefore this deliverable has become red. Compliance dashboards are in development to support the monitoring of system utilisation. Following the development of these, in combination with the remaining site visits, it is anticipated that this deliverable will return to being on-track by the end of Q4. Year End Delivery confidence remains high.
- 8.5) Reduce the number of service users experiencing Pathways of Care Delays (POCDs) through escalation and tracking Q1-Q4: Total numbers of Pathways of Care Delays have reduced. Number of POCDs within recent 3-month data (Sep-Nov 2024) demonstrate a 13% decrease compared with the 3-month prior (203 [Jun-Aug]: 176 [Sep-Nov]). However, this does represent a 3% increase when compared with the same period in the previous year (170 [2023]: 176 [2024]). Assessment Issues and Care Home Placement arrangements remain the highest contributing causes, making up 32% and 26% of total POCDs for this period respectively. The November position also represents an 11% decrease compared with the March 2024 baseline established as part of national monitoring and intervention (74 [Mar]: 66 [Nov]). The total number of days delayed as a result of Pathways of Care Delays has remained relatively stable (2812 [Aug]: 2836 [Nov]) representing <1% increase. This is a positive position when compared to the increases experienced by other Health Boards throughout the same time period, however, this does represent a 5% increase compared to the March 2024 baseline (2710 [Mar]: 2836 [Nov]). To reduce the number of service users experiencing Pathways of Care Delays, a Pathway of Care Delay Action Plan remains in place. Implementation is monitored through the POCD sub-group which reports into Care Action Committee.

- 8.6) Reduce the number of super-stranded patients through escalation and tracking Q1-Q4: The number of super-stranded patients has reduced by 37% by the end of Q3 (12 [Dec]: 19 [Sep]) and has reduced by 20% when compared with the previous Q4 baseline (12 [Dec]: 15 [Q4,23/24]. This will continue to be monitored through the Power BI dashboard to enhance monitoring of super-stranded patients, as well as monitoring through the POCD sub-group which reports into Care Action Committee.
- 8.8) Consider Expansion of Discharge Liaison Officer Q3-Q4: Due to the implementation of the colocation work and subsequent Integrated Flow Hub development, the Discharge Liaison Officer Impact Assessment was unable to progress in Q3. However, funding was identified through the Six Goals for Urgent and Emergency Care to pilot and expansion of the role through recruitment to a Mid Powys role. Recruitment to this post is currently underway with an anticipated start date of March 2025.
- 8.9) Reduce average length of stay throughout Powys, through escalation and tracking Q1-Q4: Average length of stay has reduced by 12% throughout Q3 (48.67 [Sep]: 42.80 [Dec]). This represents a 2% reduction when compared with the same period of the previous year (43.49 [Dec 23]: 42.80 [Dec 24]).

Commentary on red rated actions: N/A

Progress against key actions and milestones

Key Areas of Delivery	*Key Deliverables*	*Lead Executive*	*BRAG ('not due' already greyed out)*				*Year End Delivery Confidence Assessment* 0 = Original			
			Q1	Q2	Q3	Q4	0	Q1	Q2	Q3
Implement a Digital Patient Flow System	8.1) Complete test and pilot phases of newly developed Digital Patient Flow System Q1	ED AHPHS&D	Blue	Blue	Blue		H	H	H	High
	8.2) Launch and roll-out of Digital Patient Flow System Q2			Blue	Blue		H	H	H	High
	8.3) Embed Digital Patient Flow System into standard practice and broaden user operability Q3				Amber		H	H	H	High
	8.4) Review and refine Digital Patient Flow System, begin to strengthen beyond minimum viable product Q4						H	H	H	High
Improved Approach to Pathways of Care Delays (POCD)	8.5) Reduce the number of service users experiencing Pathways of Care Delays (POCDs) through escalation and tracking Q1-Q4	ED PCC&MH	Green	Amber	Amber		H	H	M	Medium
	8.6) Reduce the number of super-stranded patients through escalation and tracking Q1-Q4		Green	Amber	Green		H	H	M	Medium

Improved Approach to Supporting People to Leave Hospital Fitter and Faster	8.7) Embed discharge liaison officer posts throughout Powys Q1-Q2		Green	Blue	Blue		H	H	H	High
	8.8) Consider Expansion of Discharge Liaison Officer Q3-Q4				Amber		H	H	H	High
	8.9) Reduce average length of stay throughout Powys, through escalation and tracking Q1-Q4		Green	Amber	Green		H	H	M	Medium

Formal change request (Please tick as applicable and provide explanation below)			
Change in Scope	N/A	**Change in Timescale**	N/A

Executive Director Sign Off	Elaine Lorton (Executive Director of Primary Care, Community and Mental Health)

Strategic Priority 9 – Deliver the Six Goals Plan for Urgent and Emergency Care focusing on what works for the Powys population

Executive Lead - Executive Director of Primary Care, Community and Mental Health / Executive Director of Allied Health Professions, Health Sciences and Digital

Intended Outcome/ Impact

- People home fitter and faster
- A co-ordinated and evidence based Urgent and Emergency Care offer across complex health and care systems used by the Powys population
- Effective and efficient locally provided services including optimised minor injuries provision and bed utilisation to ensure patient flow

Commentary on Progress in this Quarter:

- 9.2) Broadening the knowledge and skills of MIU staff in Powys Q1-Q4: Two additional non-medical prescribers were scheduled to complete training throughout Q3. One successfully completed the training; one was postponed and will now commence in April. The Urgent and Emergency Care Clinical Transformation Lead is now in post with an in-depth training needs analysis underway. Overall, progress towards broadening the knowledge and skills of MIU staff remains on track.
- 9.5) Implement optimised model as part of winter response strategy Q3: System challenges have prevented the implementation of a truly optimised model; therefore this deliverable has been marked as red. Further work is needed to enhance collaborative working with partners. Work is underway to enhance partnership working and move toward a more optimal model for delivery of care.

- 9.7) Commence monthly aggregate reporting of D2RA Measures Q1-Q3: The Digital Patient Flow System: Powys DigiFLO is now live. Work has been completed to transition data sourcing for submission to Powys DigiFLO. This has enabled monthly aggregate reporting of all national D2RA Measures in-line with national expectations and timelines.
- 9.8) Improve data quality and confidence of D2RA Measure reporting Q3-4: The transition from census-based data collection to monthly aggregate reporting for all D2RA measures has been successfully achieved through the roll-out of Powys DigiFLO; representing a significant improvement in data quality and availability. Ongoing efforts are focused on providing training and guidance to enhance utilisation and support the integration of Powys DigiFLO into routine practice, further strengthening data capture, quality, and confidence into Q4.
- 9.9) Expansion of dedicated pathway capacity Q1-4: To enhance the capacity for Pathway 1, an adaptation of the specification of Home First and the rehabilitation bridging team as part of the Section 33 agreement with Powys County Council has been under consideration, with work undertaken to develop a proposed future service design. An Executive Paper is to be presented to the Executive Committee and Powys Teaching Health Board and Powys County Council Joint Leadership Team 15 January; the outcome of this will inform next steps.

Commentary on red rated actions: N/A

Progress against key actions and milestones

Key Areas of Delivery	*Key Deliverables*	*Lead Executive*	*BRAG ('not due' already greyed out)*				*Year End Delivery Confidence Assessment 0 = Original*			
			Q1	Q2	Q3	Q4	0	Q1	Q2	Q3
Implement Enhanced Community Care Phase One, including the Rapid Response in the community	9.1) Scope the need for a Rapid Response service Q1	ED PCC&MH	Amber	Amber	Amber		H	H	H	High
	9.2) Broadening the knowledge and skills of MIU staff in Powys Q1-Q4		Green	Green	Green		H	H	H	High
Expand Therapy Led Rehabilitation	9.3) Embed new Standard Operating Procedure (SOP) and Key Performance Indicators (KPIs) for Therapy Led Rehabilitation at Mid-Powys Intermediate Care Centre (Glan Irfon) Q1	ED AHPS&D	Blue	Blue	Blue		H	H	H	High
	9.4) Enhance partnership and collaboration to ensure targeted patient referral and access, as well as appropriate service utilisation Q2			Blue	Blue		H	H	H	High
	9.5) Implement optimised model as part of winter response strategy Q3				Amber		H	H	H	Medium

	9.6) Review of SOP and operational model including PROMS to inform the way forward Q4						H	H	H	High
Enhance and expand D2RA Pathway utilisation	9.7) Commence monthly aggregate reporting of D2RA Measures Q1-Q3	ED PCC&MH	Green	Green	Blue		M	H	H	High
	9.8) Improve data quality and confidence of D2RA Measure reporting Q3-4				Green		H	H	H	High
	9.9) Expansion of dedicated pathway capacity Q1-4		Green	Green	Green		M	M	M	High

Formal change request (Please tick as applicable and provide explanation below)			
Change in Scope	N/A	**Change in Timescale**	N/A

Executive Director Sign Off	Claire Madsen (Executive Director of Allied Health Professions, Health Sciences and Digital) Elaine Lorton (Executive Director of Primary Care, Community and Mental Health)

Workforce Futures

Strategic Priority 10: Transformation and Sustainability

Executive Lead – Executive Director of People and Culture

Intended Outcome/ Impact

- Strategic workforce planning with creative, innovative and effective approaches
- Sustainable workforce model with associated reduction in vacancies, agency usage and a greater pipeline of potential recruits
- Home grown capability in rural healthcare, with associated improvements in patient care and experience

Commentary on Progress in this Quarter:

- 10.3) Scope opportunities from national programmes for international recruitment for Mental Health - Mental Health Registered Nurses (RNs) recruited to and opportunities have now been identified
- 10.3) Mental Health RNs recruited to and opportunities have now been identified

Commentary on red rated actions: N/A

Progress against key actions and milestones

Key Areas of Delivery	*Key Deliverables*	*Lead Executive*	*BRAG ('not due' already greyed out)*				*Year End Delivery Confidence Assessment 0 = Original*			
			Q1	Q2	Q3	Q4	0	Q1	Q2	Q3
Grow the knowledge and capabilities of managers to develop strategic workforce plans aligned to the Accelerated Model of Care	10.1) Cohort of managers (who are required to) who have completed training Q2 & Q4	ED P&C		Green			H	M	M	High
On board a further 3 cohorts of internationally trained Adult Nurses targeting areas with high variable pay spend Explore the potential to recruit internationally trained Mental Health Nurses and Medics	10.2) On board Cohorts 1, 2 and 3 for 24/25 Q2 & Q4			Green			H	H	H	High
	10.3) Scope opportunities from national programmes for international recruitment for Mental Health Q3				Green		H	H	H	High
Launch a second cohort of the Aspiring Nurse Programme with HEIW and University partners (improving access for Powys based pre-registered students to the Nurse Degree Programme)	10.4) Agreed plans and funding arrangements in partnership with HEIW and FE/ HEI providers Q2			Blue	Blue		H	H	H	High
	10.5) Report on the recruitment rates of the programme Q4						H	H	H	High
	10.6) Ensuring there is an opportunity for a Welsh essential recruitment offer Q4						H	H	H	High
Generate interest from the younger generation in a rural health and care	10.7) Evaluate the Academy Careers and Education Enterprise Scheme (ACEEs) and develop plans for 2024/25 academic year Q1		Blue	Blue	Blue		H	H	H	High

career through the Academy Career and Education Enterprise Scheme (ACEES)	10.8) Report on the development plans for 2024/25 academic year Q3				Blue		H	H	H	High

Formal change request (Please tick as applicable and provide explanation below)			
Change in Scope	N/A	**Change in Timescale**	N/A

Executive Director Sign Off	Debra Wood Lawson (Executive Director of People and Culture)

Strategic Priority 11: A Great Place to work

Executive Lead – Executive Director of People and Culture

Intended Outcome/ Impact

- The health board is a great place to work, with positive organisational and team climates, high levels of staff satisfaction, engagement and wellbeing
- Associated improvements in recruitment and retention and reductions in workplace absences
- Staff are able to raise concerns and speak up safely and there is clarity on standards of behaviour and role expectations

Commentary on Progress in this Quarter:

- 11.5) Refresh the Chat2Change plan – Although this was categorised as on track in Q2, this has now been completed within Q3.
- 11.9) Pilot Tier 2 programme – Remains as Amber due to pressures within the system

Commentary on red rated actions: N/A

Progress against key actions and milestones

Key Areas of Delivery	*Key Deliverables*	*Lead Executive*	*BRAG ('not due' already greyed out)*	*Year End Delivery Confidence Assessment* *0 = Original*

			Q1	Q2	Q3	Q4	0	Q1	Q2	
Deliver the actions set out in the national Nurse Retention Plan	11.1) Complete the nurse retention self-assessment tool Q1	ED P&C	Blue	Blue	Blue		H	H	H	High
	11.2) Undertake a gap analysis and deep dive of data and intelligence, to understand retention and priorities Q2			Blue	Blue		H	H	H	High
Ensure a clear mechanism for staff to raise concerns and support a culture of psychological safety, so staff feel able to speak up.	11.3) Introduce the Speaking Up Safely 'Your Voice' Portal on staff intranet Q1		Blue	Blue	Blue		H	H	H	High
	11.4) Introduce team activities/briefings Q2			Amber	Blue		H	H	H	High
	11.5) Refresh the Chat2Change plan Q2			Green	Blue		H	H	H	High
	11.6) Embed the Speaking Up Safely Framework Q4						H	H	H	High
Roll out Tier 1 of clinical leadership programme	11.7) Deliver the Tier 1 programme at a rate of 1 course per month Q1-2		Blue	Blue	Blue		H	H	H	High
Develop a pilot for Tier 2	11.8) Develop the Tier 2 programme Q2			Amber	Amber		H	H	M	Medium
	11.9) Pilot Tier 2 programme Q3				Amber		H	M	M	Medium
Design a Charter with leadership expectations of managers responsibilities in setting standards of behaviour, engaging with staff and creating a great place to work	11.10) Develop draft Charter and resources for consultation and feedback Q1		Blue	Blue	Blue		H	H	H	High
	11.11) Consult with Executive team, Trade Unions and Chat2Change group Q2			Blue	Blue		H	H	H	High
	11.12) Launch Charter Q3				Blue		H	H	H	High

Formal change request (Please tick as applicable and provide explanation below)				
Change in Scope	N/A	**Change in Timescale**	N/A	
Executive Director Sign Off	Debra Wood Lawson (Executive Director of People and Culture)			

Strategic Priority 12: Employee Health and Wellbeing

Executive Lead – Executive Director of People and Culture

Intended Outcome/ Impact

- Staff report positively about their health and wellbeing at work, feel supported and have access to wellbeing initiatives that meet their needs
- Staff across the organisation demonstrate compassionate leadership in their everyday work
- Managers are able to utilise workforce policy and guidance to support staff to remain in/return to work

Commentary on Progress in this Quarter:

Commentary on red rated actions: N/A

Progress against key actions and milestones

Key Areas of Delivery	*Key Deliverables*	*Lead Executive*	*BRAG ('not due' already greyed out)*				*Year End Delivery Confidence Assessment 0 = Original*			
			Q1	**Q2**	**Q3**	**Q4**	**0**	**Q1**	**Q2**	**Q3**
Regular access to wellbeing roadshows and initiatives which support health	12.1) Undertake a series of wellbeing roadshows across the county Q4	ED P&C					H	H	H	High

Embed Compassionate Leadership model to underpin approach to staff wellbeing	12.2) Deliver two Compassionate Leadership courses per month Q1-Q4 Quarterly Update		Green	Green	Green		H	H	H	High
Develop the capability of managers in relation to Managing Attendance at work policy to support staff to return to work or stay in work	12.3) Review and republication of the managing attendance at work toolkit Q1		Blue	Blue	Blue		H	H	H	High
	12.4) Delivery of targeted / bespoke sessions to managers Q1-Q4 Ongoing		Green	Green	Green		H	H	H	High
Undertake regular Team Climate surveys and feedback to service managers to identify ways they can support the wellbeing of their staff	12.5) Undertake surveys targeting one service per quarter Q1-Q4 Quarterly Update		Green	Amber	Green		H	H	H	High

Formal change request (Please tick as applicable and provide explanation below)			
Change in Scope	N/A	**Change in Timescale**	N/A
Executive Director Sign Off	Debra Wood Lawson (Executive Director of People and Culture)		

Strategic Priority 13: Equalities and Welsh Language

Executive Lead – Executive Director of People and Culture

Intended Outcome/ Impact

- The health board is dynamic in promoting and achieving equality as an employer and employees report positive experiences and support
- The health board takes a pro-active wider role as an anchor institution in the community, leveraging its importance in the Foundational Economy
- There is an 'Equality Friendly' culture with a well trained workforce and effective utilisation of assistive technology, translation and interpretation

Commentary on Progress in this Quarter:

- 13.3) Achieve workplace certifications for Age-Friendly Employer, Disability Confident and Hate Crime Charter – Due in Q4 but with a low level of delivery confidence. Due to capacity issues work has not been progress as quickly as expected. As a result this has been identified as a piece of work to be rolled over to be included within the Integrated Plan 2025/26. (Relating to Q4)

Commentary on red rated actions: N/A

Progress against key actions and milestones

Key Areas of Delivery	*Key Deliverables*	*Lead Executive*	*BRAG ('not due' already greyed out)*				*Year End Delivery Confidence Assessment* *0 = Original*			
			Q1	**Q2**	**Q3**	**Q4**	**0**	**Q1**	**Q2**	**Q3**
Continue the rollout of the Gender Awareness programme	13.1) Updates on Gender Awareness provided in Equality Annual Report Q4	ED P&C					H	H	H	High
Integration of Welsh Language into the wider Managers' Training Programme	13.2) Continuous programme of training Q4						H	H	H	High
Commence the implementation of the objectives set out in the Strategic Equality Plan	13.3) Achieve workplace certifications for Age-Friendly Employer, Disability Confident and Hate Crime Charter Q4							H	M	Low
	13.4) Sensory loss work: deployment of assistive technologies & Sign Live Q4						H	H	M	Medium
Continue to monitor the use and uptake of Online translation to reduce costs and improve access to BSL and foreign language interpretation	13.5) Provide an update in relation to the use of online translation Q2-Q4			Green	Green		H	H	H	High
Begin work on the new Welsh in Healthcare Strategy including the introduction of the new Welsh	13.6) System designed and functionality finalised Q1		Green	Green	Green		H	H	H	High

Language recruitment assessment system.															

Formal change request (Please tick as applicable and provide explanation below)			
Change in Scope	N/A	**Change in Timescale**	N/A

Executive Director Sign Off	Debra Wood Lawson (Executive Director of People and Culture)

Digital First

Strategic Priority 14: Citizen centred care and support

Executive Lead - Executive Director of Allied Health Professions, Health Sciences and Digital

Intended Outcome/ Impact

- Efficient and effective digital approaches used to improved citizen centred care and support – with improved patient engagement, access and control
- Digital enables patients and service users to take an active part in their own health & wellbeing
- Greater communication at all points of access and delivery in a rural healthcare system

Commentary on Progress in this Quarter:

- 14.3) The virtual Consultation platform, current supplier has been extended to a further 12 month contract and will ensure business continuity for services using VC. The new contract commences April 2025.
- 14.3) A 12-month contract extension with Attend Anywhere is underway to help clinicians continue offering virtual consultations.

Commentary on red rated actions: N/A

Progress against key actions and milestones

Key Areas of Delivery	*Key Deliverables*	*Lead Executive*	*BRAG ('not due' already greyed out)*				*Year End Delivery Confidence Assessment 0 = Original*			
			Q1	**Q2**	**Q3**	**Q4**	**0**	**Q1**	**Q2**	**Q3**
Improve awareness and access to their digital appointment	14.1) Introduce patient portal for managing appointments Q4	ED AHPHS&D					H	H	L	Low
Improve awareness of and access to the NHS Wales App	14.2) Support the development of the NHS Wales App to include Cross Border pathway Q4						M	M	L	Low
Transition to an alternative virtual consultation platform	14.3) Provide a replacement virtual consultation platform across Powys Q3				Green		H	H	M	High

Formal change request (Please tick as applicable and provide explanation below)			
Change in Scope	N/A	**Change in Timescale**	N/A

Executive Director Sign Off	Claire Madsen (Executive Director of Allied Health Professions, Health Sciences and Digital)

Strategic Priority 15: Leadership, Partnership and Alliances

Executive Lead - Executive Director of Allied Health Professions, Health Sciences and Digital

Intended Outcome/ Impact

- Digital First supports leadership and partnership planning and decision making
- Well led Digital Teams providing excellent services and support for staff and patients, to support and improve the delivery of care
- Increased efficiency and optimisation of system use to reduce administrative and repetitive tasks

Commentary on Progress in this Quarter:

Commentary on red rated actions:

- 15.2) The Cross Border programme delays is escalated monthly at the Executive Committee. PTHB working with DHCW to aim to complete by March 31st 2025, with a clear steer from PTHB CEO (Relating to Q2)

Progress against key actions and milestones

Key Areas of Delivery	*Key Deliverables*	*Lead Executive*	*BRAG ('not due' already greyed out)*				*Year End Delivery Confidence Assessment* *0 = Original*			
			Q1	**Q2**	**Q3**	**Q4**	**0**	**Q1**	**Q2**	**Q3**
Transition of ICT Service Support; Digital Clinical partnership with Experience Level Agreements (XLA)	15.1) Target Operating Model Implementation Q3	ED AHPHS&D			Blue		H	H	M	High
Continue engagement with NHS England to improve clinical cross border pathways	15.2) Improve data flows of clinical information into our All Wales architecture to support delivery of care Q2			Red	Red		L	L	L	Low
Scope requirements for Integrated Shared Care Record	15.3) Enable front line staff to access digital clinical information across multiple disciplines Q4						M	M	M	Low
Provide opportunities to improve Digital literacy across the HB	15.4) Upskill, train and support staff to improve confidence in using digital systems Q4						H	H	H	Low

Formal change request (Please tick as applicable and provide explanation below)

Change in Scope	N/A	**Change in Timescale**	N/A

Executive Director Sign Off	Claire Madsen (Executive Director of Allied Health Professions, Health Sciences and Digital)

Strategic Priority 16: Enabling Efficiency and effectiveness

Executive Lead - Executive Director of Allied Health Professions, Health Sciences and Digital

Intended Outcome/ Impact

- Improved efficiency and streamlining – to support decision making and delivery of safe and timely care
- Improved staff / user and patient experience; greater engagement and associated improvements in healthcare system utilisation (e.g. Reduced DNAs)
- Centralised maintenance and a reduction in the carbon footprint

Commentary on Progress in this Quarter:

- 16.1) Ensuring the system gaps are fully understood to meet the needs of the health board and standardise the approach to recording – Progress is slow due to conflicting priorities (Relating to Q2)

Commentary on red rated actions:

- 16.4) The Cross Border programme delays is escalated monthly at the Executive Committee. PTHB working with DHCW to aim to complete by March 31st 2025, with a clear steer from PTHB CEO (Relating to Q2)

Progress against key actions and milestones

Key Areas of Delivery	*Key Deliverables*	*Lead Executive*	*BRAG ('not due' already greyed out)*				*Year End Delivery Confidence Assessment* 0 = Original			
			Q1	Q2	Q3	Q4	0	Q1	Q2	Q3
Whole system application review to standardise digital system access and improve efficiencies	16.1) Ensuring the system gaps are fully understood to meet the needs of the health board and standardise the approach to recording Q2	ED AHPHS&D		Amber	Red		M	M	M	Low

Complete ePMA (Electrotonic Prescribing and Medicines Administration) pre-implementation phase	16.2) Completion of a Business case to roll out (inpatient & outpatient) Q2			Blue	Blue		M	M	H	High
Award ePMA contract	16.3) Develop, build, test and implement the ePMA system Q4						M	M	H	Medium
Finalise cross border clinical records sharing project	16.4) Improve data flows of clinical information into our All Wales architecture to support delivery of care Q2			Red	Red		M	M	L	Low
Review replacement of WCCIS	16.5) Implement a replacement community system that supports the delivery and recording of patient care Q4 (NB - Change in Timescale from Q1-Q4)		Amber	Red	Red		H	M	M	Low
Implement print management solution	16.6) Replace and deliver new multi-functional devices across the HB Q1		Blue	Blue	Blue		H	H	H	High
Introduce digital clinical appointment letters	16.7) Adoption across all services using WPAS to digitally engage with patients Q4						M	M	M	Low

Formal change request (Please tick as applicable and provide explanation below)			
Change in Scope	N/A	**Change in Timescale**	N/A

Executive Director Sign Off	Claire Madsen (Executive Director of Allied Health Professions, Health Sciences and Digital)

Strategic Priority 17: Infrastructure and security

Executive Lead - Executive Director of Allied Health Professions, Health Sciences and Digital

Intended Outcome/ Impact

- Improved reliability and supportability of digital infrastructure
- Reduce and where possible remove single points of failure in the digital estate; reduce likelihood of single component outages
- Improved cyber security posture

Commentary on Progress in this Quarter:

Commentary on red rated actions: N/A

Progress against key actions and milestones

Key Areas of Delivery	*Key Deliverables*	*Lead Executive*	*BRAG ('not due' already greyed out)*				*Year End Delivery Confidence Assessment* *0 = Original*			
			Q1	Q2	Q3	Q4	0	Q1	Q2	Q3
Improve network Connectivity and reliability	17.1) Upgraded core infrastructure across all areas in the Health Board Q4	ED AHPHS&D	Amber	Green	Green		M	L	M	Medium
Improve telephony and collaboration tools	17.2) Procure and implement new telephony system Q4		Amber	Green	Blue		M	H	H	Medium
Improve application availability and resiliency	17.3) Implement enterprise level availability technologies to support resilience across the Health Board Q2			Blue	Blue		M	L	H	High
Continue to improve cyber security posture	17.4) Replace and update Firewall authentication technology across the Health Board and migrate applications Q4		Red	Red	Red		M	L	H	Low
Align and upgrade legacy operating systems	17.5) Removal of legacy and unsupported operating systems to support resilience Q3				Green		H	M	H	High

Formal change request (Please tick as applicable and provide explanation below)

Change in Scope	N/A	**Change in Timescale**	N/A

Executive Director Sign Off	Claire Madsen (Executive Director of Allied Health Professions, Health Sciences and Digital)

Strategic Priority 18: Big Data and Artificial Intelligence

Executive Lead - Executive Director of Allied Health Professions, Health Sciences and Digital

Intended Outcome/ Impact

- Increased access, quality and trust in health and care data available in near real time, promoting complete transparency of data
- Data collected consistently, cutting down manual/paper processes and releasing administration time
- 'Cloud first' approach with robust, advanced and secure reporting solutions; use of Data Platform Machine Learning and predictive modelling

Commentary on Progress in this Quarter:

- 18.1) Provide the necessary tools to allow staff to access a 'Data Self-Service' to review a single source of data – Platform / tools now created and made available to services finance being the early adopters. Next phase is onboarding of additional services.
- 18.4) Create a Data Catalog that is accessible by the entire Health Board – The catalog has been created but not yet exposed to the wider health board. This will be progressed during 2025/26 through a robust comms plan. (Relating to Q2)
- 18.5) Commence transition from the IFOR Reporting platform to a cloud hosted platform – Migration 90% complete with remaining 10% to be completed during Q4. This will lead to the decommissioning of legacy reporting software.

Commentary on red rated actions:

- 18.2) Develop and implement a secure & robust Platform Q3 – currently on hold due to other priorities and system replacement within Powys Council Social Care Services (procurement complete and contract awarded) - will need to move to 2025/26
- 18.8) Design and deliver a framework to adopt Machine Learning models Q3 – currently on hold due to other priorities and dependant on recruitment and the admin review priorities

Progress against key actions and milestones

Key Areas of Delivery	*Key Deliverables*	*Lead Executive*	*BRAG ('not due' already greyed out)*	*Year End Delivery Confidence Assessment* *0 = Original*

			Q1	Q2	Q3	Q4	0	Q1	Q2	Q3
Onboard services to new Business Intelligence platform and adopt single source of truth for data	18.1) Provide the necessary tools to allow staff to access a 'Data Self-Service' to review a single source of data Q3	ED AHPHS&D			Green		M	M	M	High
Creation of a Health & Care Data Platform	18.2) Develop and implement a secure & robust Platform Q3				Red		M	M	M	Low
Modernise data processes	18.3) Plan and deliver a data collection framework Q2			Blue	Blue		M	M	H	High
Introduce a Data Catalog to enable users to discover, understand, and use the data they need to make informed decisions	18.4) Create a Data Catalog that is accessible by the entire Health Board Q2			Amber	Amber		M	M	H	Medium
Migration of legacy reports and data processes from IFOR to the cloud	18.5) Commence transition from the IFOR Reporting platform to a cloud hosted platform Q3, Q4				Green		M	M	H	High
Accelerate use of Robotic Processing Automation	18.6) Plan and deliver a 'RPA Framework' and Operating Model across the HB Q4						H	H	H	Low
Improve the accuracy, completeness, of data quality using advanced technologies and best practices	18.7) Identify required resource and approach to improve Data Quality Q4	ED AHPHS&D					H	H	H	Low
Adopt Machine learning toolkit (predictive analysis on current data sets)	18.8) Design and deliver a framework to adopt Machine Learning models Q3				Red		H	H	M	Low

Formal change request (Please tick as applicable and provide explanation below)

Change in Scope	N/A	**Change in Timescale**	X

Change in Timescale

- Develop and implement a secure & robust Platform Q3 – currently on hold due to other priorities and system replacement within Powys Council Social Care Services (procurement complete and contract awarded) - will need to move to 2025/26.

Executive Director Sign Off	Claire Madsen (Executive Director of Allied Health Professions, Health Sciences and Digital)

Innovative Environments

Strategic Priority 19: Strategic Capital

Executive Lead - Associate Director of Estates, Facilities and Support Services

Intended Outcome/ Impact

- Delivery of Capital Programme enhancements to the estate including compliance improvements
- Strategic capital programme progressed to support delivery of 'A Healthy Caring Powys' and PTHB Integrated Plan / Strategic Priorities
- Programme of works to address urgent compliance risks and infrastructure improvements

Commentary on Progress in this Quarter:

- 19.2) Hub element as phase 1. Application for funding for fees to progress Strategic Outline Case / Outline Business Case in Autumn 2025 has been submitted to Welsh Government / Integrated and Rebalancing Capital Fund (IRCF).
- 19.2) Llandrindod Wells Rural Regional Centre: £3M funding obtained to undertake part of Phase 2 programme which includes replacement windows, roofs, external access improvements and refurbishment of Westdene accommodation unit. This phase of the work is on track for completion within financial year. Business case for remaining phases will be developed in 2025/26
- 19.3) Discretionary Programme / EFAB: progressing well with largest overall programme of activity for many years but some resource gaps in Capital team.

Commentary on red rated actions: N/A

Progress against key actions and milestones

Key Areas of Delivery	*Key Deliverables*	*Lead Executive*	*BRAG ('not due' already greyed out)*				*Year End Delivery Confidence Assessment 0 = Original*			
			Q1	**Q2**	**Q3**	**Q4**	**0**	**Q1**	**Q2**	**Q3**

North Powys Wellbeing Programme	19.1) Outline Business Case Development for campus Q2	ADEF&SS		Amber	Amber		L	M	M	Medium
Llandrindod Wells Rural Regional Centre	19.2) Business Case submission in format as outlined by Welsh Government as part of endorsed Programme Business Case Q3	ADEF&SS			Amber		L	M	H	Medium
Discretionary Capital Programme including Estates Funding Advisory Board (EFAB), etc.	19.3) Discretionary Capital Programme (circa 25 projects) Q1-Q4	ADEF&SS	Amber	Green	Green		H	M	M	Medium
	19.4) EFAB Brecon Fire Q4	ADEF&SS					H	H	H	Medium
	19.5) EFAB Machynlleth Fire Q4	ADEF&SS					H	H	H	High
	19.6) Building Management Systems Ystradgynlais Q4	ADEF&SS					H	H	H	High
	19.7) Waste Compounds pan-Powys Q4	ADEF&SS					H	H	H	High
Development of Strategic Capital Plan, project pipeline	19.8) Health and Social Care, Integration and Rebalancing Capital Fund (IRCF); capital project programme Q2	ADEF&SS		Green	Blue		H	M	H	High

Formal change request (Please tick as applicable and provide explanation below)			
Change in Scope	X	**Change in Timescale**	X

Change in Scope and Timescale

- 19.1) North Powys: scope now changed to phased approach with submission of SOC/OBC for Integrated Hub / Front Door element only in Q3 2025/26
- 19.2) Llandrindod: Welsh Government Capital Prioritisation Process has put business case submissions on hold. Progression in year of £3M element of larger Phase 2 programme.

Executive Director Sign Off	Wayne Tannahill (Associate Director of Estates, Facilities and Support Services)

Strategic Priority 20: Estates Strategy

Executive Lead:- Associate Director of Estates, Facilities and Support Services

Intended Outcome/ Impact

- Structured plan for future estate development / health and care needs

Commentary on Progress in this Quarter:

- 20.1) Estates Strategy has been progressed in terms of 'where are we now' and 'how do we get there' but key 'where do we want to be' element is dictated by Service Strategy which is being driven by Better Together / Routemap to Sustainability work which is ongoing and an organisation priority.

Commentary on red rated actions: N/A

Progress against key actions and milestones

Key Areas of Delivery	*Key Deliverables*	*Lead Executive*	*BRAG ('not due' already greyed out)*				*Year End Delivery Confidence Assessment 0 = Original*			
			Q1	**Q2**	**Q3**	**Q4**	**0**	**Q1**	**Q2**	**Q3**
Draft Estates Strategy	20.1) Estates Strategy; initial draft for review Q1	ADEF&SS	Amber	Amber	Amber		M	M	M	Medium

Formal change request (Please tick as applicable and provide explanation below)

Change in Scope	X	**Change in Timescale**	X

Change in Scope and Timescale

- 20.1) Estates Strategy has interdependency on the Better Together activity which will define 'where do we want to be' in terms of the Service Strategy – the Estates Strategy will respond to this and enable change. Timeline currently uncertain.

Executive Director Sign Off	Wayne Tannahill (Associate Director of Estates, Facilities and Support Services)

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Strategic Priority 21: Environmental Management and Decarbonisation

Executive Lead - Associate Director of Estates, Facilities and Support Services

Intended Outcome/ Impact

- Reduction in Carbon emissions and ambition for public sector Net Zero by 2030
- Enhancement and protection of biodiversity and development of community group activity
- Improved energy efficiency and carbon reduction

Commentary on Progress in this Quarter:

- 21.1) Good progress in all elements - some concern around progress reporting against Decarbonisation targets as the baseline data provided by NWSSP-Procurement has been independently reassessed.

Commentary on red rated actions: N/A

Progress against key actions and milestones

Key Actions	*Key Milestones*	*Lead Executive*	*BRAG ('not due' already greyed out)*				*Year End Delivery Confidence Assessment 0 = Original*			
			Q1	**Q2**	**Q3**	**Q4**	**0**	**Q1**	**Q2**	**Q3**
Decarbonisation	21.1) Decarbonisation Strategic Delivery Plan – actions as set out for 2024/2025 Q1-Q4	ADEF&SS	Green	Green	Green		H	H	H	High
Biodiversity	21.2) Enhancement and protection of biodiversity including community group engagement Q1-Q4		Green	Green	Green		H	H	H	High
Energy efficiency	21.3) Implementation of energy efficiency interventions pan-Powys: Re:fit programme / Invest to Save Q4						M	M	H	High

Formal change request (Please tick as applicable and provide explanation below)

Change in Scope	N/A	**Change in Timescale**	N/A

Executive Director Sign Off	Wayne Tannahill (Associate Director of Estates, Facilities and Support Services)

Strategic Priority 22: Property

Executive Lead - Associate Director of Estates, Facilities and Support Services

Intended Outcome/ Impact

- Integrated Working in agile environments to maximise space efficiency

Commentary on Progress in this Quarter:

- 22.1) Spa Road occupation has progressed, enabling release of leased premises. Some challenges with staff adoption of agile working principles. Local Authority have confirmed intent to occupy part of building for collaborative working / Integrated Hub – this will allow plans for building configuration to be finalised – this will require bid to IRCF for space reconfiguration.

Commentary on red rated actions: N/A

Progress against key actions and milestones

Key Actions	*Key Milestones*	*Lead Executive*	*BRAG ('not due' already greyed out)*				*Year End Delivery Confidence Assessment 0 = Original*			
			Q1	**Q2**	**Q3**	**Q4**	**0**	**Q1**	**Q2**	**Q3**
Integrated Hubs / Agile Working	22.1) Develop Spa Road, Llandrindod Wells as Integrated Hub Q3	ADEF&SS			Amber		H	M	M	Medium

Formal change request (Please tick as applicable and provide explanation below)

Change in Scope	N/A	**Change in Timescale**	N/A

Executive Director Sign Off	Wayne Tannahill (Associate Director of Estates, Facilities and Support Services)

Transforming in Partnership

Strategic Priority 23: Key Strategic Partnerships

Executive Leads - Executive Director of Public Health / Director of Corporate Governance / Board Secretary / Executive Director of Planning, Performance and Commissioning

Intended Outcome/ Impact

- Whole system approach to health and wellbeing to leverage benefit of collaborative working for population of Powys (and wider region as appropriate)
- Whole system value and effectiveness – best use of public purse for population
- Effective partnership governance and oversight

Commentary on Progress in this Quarter:

Commentary on red rated actions:

- 23.1) Framework to be developed, agreed and operationalised Q3 – Timescale change to Q4

Progress against key actions and milestones

Key Actions	*Key Milestones*	*Lead Executive*	*BRAG ('not due' already greyed out)*				*Year End Delivery Confidence Assessment* *0 = Original*			
			Q1	**Q2**	**Q3**	**Q4**	**0**	**Q1**	**Q2**	**Q3**

PTHB Partnership Assurance and Governance Framework to be developed	23.1) Framework to be developed, agreed and operationalised Q3	DCG/ ED PP&C			Red		M	M	L	Low

Formal change request (Please tick as applicable and provide explanation below)			
Change in Scope	N/A	**Change in Timescale**	X

Change in Timescale

23.1) Framework to be developed, agreed and operationalised Q3 – Timescale change to Q4

Executive Director Sign Off	Mererid Bowley (Executive Director of Public Health) Helen Bushell (Director of Corporate Governance / Board Secretary) Nicola Johnson (Executive Director of Planning, Performance and Commissioning)

Strategic Priority 24: Commissioning, Performance, Planning

Executive Lead - Executive Director of Planning, Performance and Commissioning

Intended Outcome/ Impact

- Integrated commissioning, performance and planning delivering 'A Healthy Caring Powys' and the PTHB Integrated Plan
- Effective mechanisms in place for strategic planning, commissioning assurance and performance management
- Supporting value, effectiveness, efficiency, quality and resilience of provider and commissioned services for Powys residents

Commentary on Progress in this Quarter:

- 24.3) Portfolio of commissioning and performance activity as noted - at risk in terms of NHSW providers not delivering required RTT and cancer performance; and due to financial pressures mainly in NHSE providers and Specialised Services.

Commentary on red rated actions: N/A

Progress against key actions and milestones

Key Actions	*Key Milestones*	*Lead Executive*	*BRAG ('not due' already greyed out)*				*Year End Delivery Confidence Assessment 0 = Original*			
			Q1	**Q2**	**Q3**	**Q4**	**0**	**Q1**	**Q2**	**Q3**
Delivery of Annual Strategic Planning Cycle	24.1) Quarterly Reporting cycle (progress against plan and strategic change) Q1-Q3	ED PP&C	Green	Green	Green		H	H	H	High
	24.2) Annual Plan Review & Development Q3-Q4				Green		H	H	H	High
Delivery of Immediate / Short / Medium and Long Term Commissioning and Performance Work Programme	24.3) Portfolio of commissioning and performance activity as noted Q1-Q4		Green	Green	Amber		H	H	H	High

Formal change request (Please tick as applicable and provide explanation below)			
Change in Scope	N/A	**Change in Timescale**	N/A

Executive Director Sign Off	Nicola Johnson (Executive Director of Planning, Performance and Commissioning)

Strategic Priority 25: Governance

Executive Lead - Director of Corporate Governance / Board Secretary

Intended Outcome/ Impact

- Decisive and effective decision making supported by assurance, oversight and effective management of risks
- Appropriately skilled, trained and informed Board
- Excellent Board and Executive administration and governance advice and support

Commentary on Progress in this Quarter:

Commentary on red rated actions: N/A

Progress against key actions and milestones

Key Actions	*Key Milestones*	*Lead Executive*	*BRAG ('not due' already greyed out)*				*Year End Delivery Confidence Assessment 0 = Original*			
			Q1	**Q2**	**Q3**	**Q4**	**0**	**Q1**	**Q2**	**Q3**
Board Assurance Framework	25.1) Board Assurance Framework (BAF) is an integrated part of every Board meeting Q1	DCG	Green	Green	Amber		H	H	M	Medium
Board and Committee work plans aligned to the plans Board Assurance Framework and Corporate Risk Register	25.2) Board and Committee work plans are agreed, delivered and evaluated. Q1-Q4		Green	Green	Green		H	H	H	High
Board Development programme that underpins the High Performing Board programme	25.3) Board development programme x6 sessions; board briefings x12 sessions Q1-Q4		Green	Green	Green		H	H	H	High
Review Boards Risk Management Framework further embedding effective risk management	25.4) Risk management framework reviewed and fully implemented Q4						H	H	L	Medium
Corporate business systems maximising efficiency and effectiveness	25.5) Corporate business systems clearly defined and in place Q1		Green	Green	Green		H	H	H	High

Formal change request (Please tick as applicable and provide explanation below)

Change in Scope	N/A	**Change in Timescale**	N/A

Executive Director Sign Off	Helen Bushell (Director of Corporate Governance / Board Secretary)

Strategic Priority 26: Effective systems and delivery of engagement and communication

Executive Lead - Director of Corporate Governance / Board Secretary

Intended Outcome/ Impact

- Clear and effective communication and engagement between the health board and the population it serves
- Communication activity supports strategic priorities and focuses on the management of principal risks
- Increased coherency across partners with a shared approach to public voice and insight to drive positive change

Commentary on Progress in this Quarter

- Key actions are on schedule at end Q3, with a year-end delivery confidence remaining high. However, it is recognised that there will need to be continued review and reprioritisation particularly to reflect emerging requirements relating to the development of the future shape of safe and sustainable health services.
- The challenging financial situation for the NHS, and locally for PTHB, has required a renewed focus on raising awareness of potential areas of cost improvement and supporting action across the health board to live within our means. This includes support for the development of a number of potential actions early in Q4 to improve the in-year financial position.
- A key focus for the engagement and communication team during Q3 has been the conclusion of engagement analysis following a period of engagement on a number of proposals for temporary changes to health services to ensure quality, financial sustainability and value. Recommendations on the next steps were presented for consideration by a meeting in public of the Board early in Q3, and following the decision to proceed the focus moved to implementation actions including continued awareness of the temporary changes and promotional materials.
- Continued progress is also being made through the Powys Engagement and Insight Network (a joint sub-group of the Public Services Board and Regional Partnership Board) to develop a shared approach to co-production for Powys. During Q3, a new Insight Report has been established, bringing together insights from engagement activity by RPB and PSB partners to support organisational and partnership development and decision-making.
- Promotion of flu and COVID vaccination has been a key focus during Q3, alongside wider winter awareness and readiness. A number of adverse weather events including Storm Bert and Storm Darragh have also required significant reactive comms support to reduce risk and impact for the organisation and for communities
- Looking ahead to the medium-to-long term sustainability of health and care services, with governance arrangements for the next phase of Better Together becoming established, a key area of work has been preparedness for engagement activity anticipated from Q4 and focus will be needed on ensuring effective, appropriate and compliant engagement and communication within available resources.

Commentary on red rated actions: N/A

Progress against key actions and milestones

Key Actions	*Key Milestones*	*Lead Executive*	*BRAG ('not due' already greyed out)*				*Year End Delivery Confidence Assessment 0 = Original*			
			Q1	**Q2**	**Q3**	**Q4**	**0**	**Q1**	**Q2**	**Q3**
Design and delivery of a programme of marketing and communication	26.1) Design and deliver annual programme of communication and marketing activity focusing on those issues offer the most strategic benefit and management of principal risks Q1-Q4	DCG	Green	Green	Green		H	H	H	High
Design and delivery of a programme of continuous and targeted engagement	26.2) Design and deliver compliant programmes of engagement and/or consultation reflecting the requirements of the health board (e.g. Better Together), local partnerships (e.g. Sustainable Powys), regional programmes (e.g. cross-border / commissioning changes) and national programmes (e.g. all-Wales and specialised services). Q1-Q4		Amber	Green	Green		H	H	H	High
Delivery of shared PSB/RPB Engagement and Participation Plan priorities	26.3) Design and deliver a shared approach to coproduction across public sector partners in the Regional Partnership Board and Public Services Board Q1-Q4		Green	Green	Green		H	H	H	High

Formal change request (Please tick as applicable and provide explanation below)

Change in Scope	N/A	**Change in Timescale**	N/A

Executive Director Sign Off	Helen Bushell (Director of Corporate Governance / Board Secretary)

Strategic Priority 27: Quality and Safety

Executive Lead - Executive Director of Nursing, Quality, Women and Family Health

Intended Outcome/ Impact

- Delivery of Quality care that meets the needs of the Powys population
- A mature and effective approach to quality embedded throughout the organisation

Commentary on Progress in this Quarter:

Commentary on red rated actions: N/A

Progress against key actions and milestones

Key Actions	*Key Milestones*	*Lead Executive*	*BRAG ('not due' already greyed out)*				*Year End Delivery Confidence Assessment 0 = Original*			
			Q1	**Q2**	**Q3**	**Q4**	**0**	**Q1**	**Q2**	**Q3**
Year 2 Maturity Plan (building on Year 1 of Duty of Quality and Candour Implementation Plan)	27.1) Duty of Quality and Candour Maturity Plan Q1-Q4	ED NQW&FH	Green	Green	Green		H	H	H	High

Formal change request (Please tick as applicable and provide explanation below)

Change in Scope	N/A	**Change in Timescale**	N/A

Executive Director Sign Off	Claire Roche (Executive Director of Nursing, Quality, Women and Family Health)

Powell,Bethan 03/02/2025 16:55:30

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 5.3

Delivery and Performance Committee	**Date: 06 February 2025**
Subject:	**Progress Against the Integrated Plan (Delivery Plan 2024-2029) for the Quarter 3 period, October to December 2024**
Approved and presented by:	Nicola Johnson, Executive Director of Planning, Performance & Commissioning
Prepared by:	Assistant Director of Planning/Planning Managers
Other Committees and meetings considered at:	Executive Committee 22 January 2025 PTHB Board 26 March 2025

PURPOSE:

This report provides the Delivery and Performance Committee with an update of the progress made against the Integrated Plan for the Q3 period (October to December 2024).

The report has been considered at the Executive Committee where any change requests made by Executive leads were collectively moderated, prior to submission to Delivery and Performance Committee.

Following consideration at Delivery and Performance Committee, this report will be provided to PTHB Board and subsequently submitted to Welsh Government, as a formal report of Progress against Plan for Q3.

RECOMMENDATION(S):

The Delivery and Performance Committee are asked to **CONSIDER** the report ahead of submission to PTHB Board and take **ASSURANCE** that there is a process in place for monitoring progress against plan.

Approve/Take Assurance	Discuss	Note
Y	Y	N

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	Y	This paper is a Strategic Paper and shows alignment across all the Health Boards wellbeing Objectives.
2. Provide Early Help and Support	Y	
3. Tackle the Big Four	Y	
4. Enable Joined up Care	Y	
5. Develop Workforce Futures	Y	

6. Promote Innovative Environments	Y	
7. Put Digital First	Y	
8. Transforming in Partnership	Y	

EXECUTIVE SUMMARY:

This report provides the Delivery and Performance Committee with an update of the progress made against the Integrated Plan for the Q3 period (October to December 2024). This is the output of the reviews carried out by each Executive Lead on their respective areas.

Once considered by the Delivery and Performance Committee, this will then be submitted to PTHB Board and finally to Welsh Government as a formal report of Progress against Plan for the Q3 period.

This is an important component of the health board's assurance and performance management regime. This is particularly relevant in the context of the Health Board's escalation status of 'targeted intervention' for strategy, finance and planning. Improvements have been made continuously to this report to enable sufficiently detailed yet concise reporting of the PTHB Integrated Plan.

BACKGROUND

This report provides the Delivery and Performance Committee with an update of the progress made against the Integrated Plan for the Q3 period (October to December 2024).

1) Development of Progress Report against Plan

Each of the 27 Strategic Priorities set out within the Integrated Plan have been reviewed and a commentary provided by Executive Leads on key achievements and challenges, where required for Q3.

An additional explanation including mitigating action is also included where any items are **BRAGG** rated as red. Executive leads were also asked to reassess their delivery confidence ratings with current confidence levels compared to that of the start of the year.

This is an important component of the Health Board's monitoring, assurance and performance management regime. This is particularly relevant in the context of the Health Board's escalation status of 'targeted intervention' for strategy, finance and planning.

Executive Lead sign off has been maintained, to ensure that the report reflects the appraisal carried out within Directorates and is given as part of the Executive Leads accountability for their portfolio and strategic priorities.

Executive Leads have had the option to request amendments via the change request process. A summary of all change requests has been included within this paper. The Delivery and Performance Committee are therefore asked to CONSIDER the report ahead of submission to PTHB Board and take ASSURANCE that there is a process in place for monitoring progress against plan.

2) Progress Summary at Q3

This report shows progress made with delivery of the actions and priorities in the Plan as reported at Q3. A delivery confidence has been reported on key deliverables in the Plan at this stage of the year.

Following discussion at Executive Committee, further analysis has been carried out, to provide a fuller and more consolidated picture of the Year To Date position and delivery confidence assessment to Year End, where possible. The charts in this version of the report have therefore been updated to provide the full Year To Date positions (rather than just the positions which were specific to Q3, which were presented in the initial report to Executive Committee). A summary of key points is also provided below.

Of the 215 key deliverables identified for completion in 2024/25, 59 have been completed (Blue) with a further 57 rated as on track for delivery (Green) as of Q3. This represents 54% of the plan with a further 20% (44) targeted for delivery in Q4 (Grey). The remaining key deliverables have been categorised as behind schedule (23) or at risk (32) representing 26% of the overall plan. A number of these have been identified as key areas to inform year 2 (2025/26) of the Health Board's 5 year plan.

Further analysis has identified the items below as behind schedule. The main areas relate to specific schemes in Community Services and Planned Care, the Major Conditions Plan and Mental Health (which is being reviewed as part of the reshaping of the Transformation Programme), and some Digital schemes due to the interdependency with national programmes.

The table below summarises areas of delivery which remain with a red BRAGG rating at the end of Quarter 3.

Strategic Priority	Area of delivery	Deliverables	Reason for delay
Early Help and Support			
Improve Access to Primary and Community Care	Optometry	Pre-registration Optometrist between primary and secondary care in Cluster(s)	Scope of role being considered by newly appointed Optometry Advisor.
		School vision and eyecare access improvements	Ongoing discussions following newly appointed Optometry Advisor.
		Scope Special School Primary Care Eyecare	This is dependent upon national pathways, led by national clinical leads. Scope of service has not been communicated to Health Boards so cannot progress.
Design and Deliver a phased Frailty and Community Model	Improve coordination of the Last Year of Life	Commence implementation including liaison with out of county providers Q3-Q4	Following the approval by national colleagues to implement a revised Treatment Escalation process in the community in Powys, work has focused on the development of the new process, including training for staff to ensure they are aware of and

			working to the new process. This has meant that the liaison with out of county providers has not taken place in Q3 and the next steps for this work will be confirmed through the Frailty & Community Model Programme Board.
Deliver the Planned Care & Diagnostics Programme	GIRFT Recommendations	Seek Consultant Urologist sessions to scope community urology service Q2-Q4	PTHB were unsuccessful in the Planned Care Transformation fund for speciality consultant sessions resulting in PTHB not being able to progress with Consultant Urologist sessions at present. A further review and plan will be developed for the 2025/26 plan.
Deliver the Planned Care & Diagnostics Programme	Referral Management Solutions	Develop referral management solution for dentistry in relation to oral cancer Q2	High quality cameras have not been purchased until the outcome and evaluation is complete for the Dermatology pilot.
Tackling the Big Four			
Develop and Deliver a Major Conditions Plan	Development of a phased major conditions transformation plan	To develop: a less siloed approach; streamline appointments, diagnostics, assessments, care and treatment plans, reviews and polypharmacy; and to improve co-ordination in the last year of life Q1- Q3 development of the plan	An Executive Lead was agreed in January 2025. An SRO has yet to be identified for the work programme and remains red in reporting. Progress has however been made in the background with focus on High-cost user data modelling which has identified co-morbidities as an area of higher spend based on patients with more than one condition. Q4 will define the priority for this to continue into 2025/26.
	Single Cancer Pathway	Review variation of Single Cancer Pathway performance across secondary care providers and reduction of backlog of those waiting over 62 days for first definitive cancer treatment Q1 – Q4	Review has been completed but there remain performance issues across commissioned services as reported through the IQPR.
Deliver the Mental Health Transformation Programme	Transformation of Adult and Community Model Phase 1 (includes alignment of Duty and Assessment Model)	Refining the baseline. Refining the modelling for the new model. Continuous engagement Q1	Awaiting baseline data in order to develop model.
		Public engagement and consultation Q2	Awaiting baseline data in order to develop model.
	Develop access to provision for sanctuary for adults	Through collaboration with stakeholders, staff and partners, design a sustainable model	This programme has been suspended due to a lack of evidence for rural areas. It is not a current priority for 2024/25.

		for a highly rural setting Q3-4	
	Take forward the next phase of work to enable access to a step-down solution for those with complex needs	Continuous engagement Q1-Q4 Explore and develop advisory options appraisal Q1 Design and workforce planning Q2 Preparation for procurement Q3-Q4	This project was paused and is not a current priority.
Digital First			
Leadership, Partnership and Alliances	Continue engagement with NHS England to improve clinical cross border pathways	Improve data flows of clinical information into our All Wales architecture to support delivery of care Q2	The Cross Border programme delays is escalated monthly at the Executive Committee. Work is ongoing with DHCW to complete by March 31st 2025.
Enabling Efficiency and Effectiveness	Whole system application review to standardise digital system access and improve efficiencies	Ensuring the system gaps are fully understood to meet the needs of the health board and standardise the approach to recording Q2	Progress is slow due to conflicting priorities.
	Finalise cross border clinical records sharing project	Improve data flows of clinical information into our All Wales architecture to support delivery of care Q2	The Cross Border programme delays is escalated monthly at the Executive Committee. Work is ongoing with DHCW to complete by March 31st 2025.
	Review replacement of WCCIS	Implement a replacement community system that supports the delivery and recording of patient care Q4	Due to national programme timescales changes target is now the end of 2025.
Infrastructure and Security	Continue to improve cyber security posture	Replace and update Firewall authentication technology across the Health Board and migrate applications Q4	Funding has not yet been secured for this. Timescale Change from Q1 to Q4.
Big Data and Artificial Intelligence	Creation of a Health & Care Data Platform	Develop and implement a secure & robust Platform Q3	Currently on hold due to other priorities and system replacement within Powys Council Social Care Services.
	Adopt Machine learning toolkit (predictive analysis on current data sets)	Design and deliver a framework to adopt Machine Learning models Q3	Currently on hold due to other priorities.
Transforming in Partnership			
Key Strategic Partnerships	PTHB Partnership Assurance and Governance	Framework to be developed, agreed and operational Q3	Timescale to change to Q4

	Framework to be developed		

Further analysis of the key deliverables still due to be delivered in Q4 identify that 80% have a delivery confidence of high or medium. This includes deliverables that are specific to Q4 and those on a rolling programme that will also conclude in Q4. More detailed information relating to this can be found in the attached report.

3) Conclusion

This report provides the Delivery and Performance Committee with an update of the progress made against the Integrated Plan for the Q3 period (October to December 2024).

Following consideration at this Committee, this report will be provided to PTHB Board and Welsh Government as a formal report of Progress against Plan for Q3 in line with national reporting requirements**.**

NEXT STEPS:

Following consideration at this Committee, this report will be provided to PTHB Board and Welsh Government as a formal report of Progress against Plan for Quarter 3 in line with national reporting requirements**.**

IMPACT ASSESSMENT - NOT REQUIRED FOR THIS REPORT

Strategic Priority	Key Areas of Delivery	Key Deliverables	Change Request Type	Description of change	Lead Director	Change approved
Early Help and Support 5: Design and Deliver a phased Frailty and Community Model	Radiology Provision across Powys (enabling implementation of RISP)	Submit capital business case for replacement of X-ray equipment to enable implementation of RISP Q1 Review x–ray provision across Powys as part of work on sustainable model Q1 Develop x-ray implementation plan and implement phase 1 Q2-Q4	Additional Exec Lead	Currently Lead Executive for delivery of RISP and these actions will be used for routine monitoring through to Executive Committee	ED PCC&MH ED PP&C to add ED AHPHS&D	Yes
Tackling the Big Four 6:Develop and Deliver a Major Conditions Plan	Tackling the Big Four - Stroke	Review National Prescribing indicators in primary care for Atrial Fibrillation; explore improvements PTHB Clinical engagement in key Strategic Programmes for Stroke (Wales and England particularly Herefordshire & Worcestershire) Incorporation of guidelines for stroke rehabilitation Q3	Change in Exec Lead	DSI&T To DPPP&C and EMD	DSI&T To DPPP&C and EMD	Yes
Tackling the Big Four 6:Develop and Deliver a Major Conditions Plan	Tackling the Big Four - Respiratory	Continue to explore options for medical cover across PTHB Q1-Q3 Provide support to Primary Care to implement Asthma plans for the asthma population Q2-Q4	Change in Exec Lead	ED AHPHS&D to ED PCC&MH	ED AHPHS&D to ED PCC&MH	Yes

Joined Up Care 8: Improve pathways of care focused on system flow	Implement a Digital Patient Flow System	Complete test and pilot phases of newly developed Digital Patient Flow System Q1 Launch and roll-out of Digital Patient Flow System Q2 Embed Digital Patient Flow System into standard practice and broaden user operability Q3 Review and refine Digital Patient Flow System, begin to strengthen beyond minimum viable product Q4	Change in Exec Lead	DSI&T to EDPCCMH	DSI&T to ED AHPHS&D	Yes
Joined Up Care 8: Improve pathways of care focused on system flow	Improved Approach to Pathways of Care Delays (POCD)	Reduce the number of service users experiencing Pathways of Care Delays (POCDs) through escalation and tracking Q1-Q4 Reduce the number of super-stranded patients through escalation and tracking Q1-Q4	Change in Exec Lead	DSI&T to EDPCCMH	DSI&T to EDPCCMH	Yes
Joined Up Care 8: Improve pathways of care focused on system flow	Improved Approach to Supporting People to Leave Hospital Fitter and Faster	Embed discharge liaison officer posts throughout Powys Q1-Q2 Consider Expansion of Discharge Liaison Officer Q3-Q4 Reduce average length of stay throughout Powys, through escalation and tracking Q1-Q4	Change in Exec Lead	DSI&T to EDPCCMH	DSI&T to EDPCCMH	Yes
Joined Up Care 9: Deliver the Six Goals Plan for Urgent and Emergency Care focusing on what works	Implement Enhanced Community Care Phase One, including the Rapid Response in the community	Scope the need for a Rapid Response service Q1 Broadening the knowledge and skills of MIU staff in Powys Q1-Q4	Change in Exec Lead	DSI&T to EDPCCMH	DSI&T to EDPCCMH	Yes

for the Powys population						
Joined Up Care 9: Deliver the Six Goals Plan for Urgent and Emergency Care focusing on what works for the Powys population	Expand Therapy Led Rehabilitation	Embed new Standard Operating Procedure (SOP) and Key Performance Indicators (KPIs) for Therapy Led Rehabilitation at Mid-Powys Intermediate Care Centre (Glan Irfon) Q1 Enhance partnership and collaboration to ensure targeted patient referral and access, as well as appropriate service utilisation Q2 Implement optimised model as part of winter response strategy Q3 Review of SOP and operational model including PROMS to inform the way forward Q4	Change in Exec Lead	DSI&T to EDAHPS&D	DSI&T to EDAHPS&D	Yes
Joined Up Care 9: Deliver the Six Goals Plan for Urgent and Emergency Care focusing on what works for the Powys population	Enhance and expand D2RA Pathway utilisation	Commence monthly aggregate reporting of D2RA Measures Q1-2 Improve data quality and confidence of D2RA Measure reporting Q3-4 Expansion of dedicated pathway capacity Q1-4	Change in Exec Lead	DSI&T to EDPCCMH	DSI&T to EDPCCMH	Yes
Digital First 16: Enabling Efficiency and effectiveness	Review replacement of WCCIS	Implement a replacement community system that supports the delivery and recording of patient care Q1	Timescale	Due to National programme timescales changes we need to realign this piece of work. The national programme now target the end of 2025. This will support the process of procurement of the system	EDAHPS&D	Yes

				for community and Mental Health. Change to Q4		
Digital First 17: Infrastructure and security	Improve network Connectivity and reliability	Upgraded core infrastructure across all areas in the Health Board Q1	Timescale	Improve network Connectivity and reliability – Procurement of hardware has been completed. Request to amend to Q4 due to capacity restraints of both PTHB and BT.	EDAHPS&D	Yes
Digital First 17: Infrastructure and security	Improve telephony and collaboration tools	Procure and implement new telephony system Q1	Timescale	As Above	EDAHPS&D	Yes
Digital First 17: Infrastructure and security	Continue to improve cyber security posture	Replace and update Firewall authentication technology across the Health Board and migrate applications Q1	Timescale	Funding has not yet been secured for this. Request to amend to Q4	ED AHPHS&D	Yes
Early Help and Support 4: Design and Deliver a phased Frailty and Community Model	Review and refine the Community Hospital model	Scope an improved approach to cognitive impairment on general wards Q1-Q2	Timescale	Pilot the (improved approach to cognitive impairment on general wards) approach Q3-Q4: The scoping work was not progressed in Q2 to provide capacity for the scoping of the Temporary Service Change proposal around the potential colocation of patients by clinical need. If the	DSI&T	Yes

				Temporary Service Change to co-locate patients is implemented, then that will need to be prioritised in-year over this action. If the Temporary Service Change to collocate patients is not implemented, then the scoping work which was not progressed in Q2 could be re-established in Q3, however this will delay the pilot into Q4 at the earliest.		
Transforming in Partnership 25: Governance	Review Boards Risk Management Framework further embedding effective risk management	Risk management framework reviewed and fully implemented Q3	Timescale	The Risk Management Framework is unlikely to be delivered fully in Q3, further progress will be made in Q3 and Q4. Some aspects (risk management software and training) may not be fully delivered until Q2 of 2025/26.	DCG	Yes
Innovative Environments SP 19 Strategic Capital	North Powys Wellbeing Programme	19.1) Outline Business Case Development for campus Q2	Change in Scope and Timescale	Scope now changed to phased approach with submission of SOC/OBC for Integrated Hub / Front Door element only in Q3 2025/26	ADEF&SS	**Yes Q3**
Innovative Environments SP 19 Strategic Capital	Llandrindod Wells Rural Regional Centre	19.2) Business Case submission in format as outlined by Welsh Government as part of endorsed Programme Business Case Q3	Change in Scope and Timescale	Welsh Government Capital Prioritisation Process has put business case submissions on hold. Progression in year of £3M element of larger Phase 2 programme	ADEF&SS	**Yes Q3**

Innovative Environments SP 20 Estates Strategy	Draft Estates Strategy	20.1) Estates Strategy; initial draft for review Q1	Change in Scope and Timescale	Estates Strategy has interdependency on the Better Together activity which will define 'where do we want to be' in terms of the Service Strategy – the Estates Strategy will respond to this and enable change. Timeline currently uncertain.	ADEF&SS	**Yes Q3**
Early Help and Support SP 5 Deliver the Planned Care & Diagnostics Programme	Referral Management Solutions	5.12) Further develop phlebotomy service Q3-Q4	Change in Timescale	Phlebotomy – This was identified for Year 2 and should not sit in this delivery plan, suggest this is removed.	ED PCC&MH	**Yes Q3**
Digital First SP 18 Big Data and Artificial Intelligence	Creation of a Health & Care Data Platform	18.2) Develop and implement a secure & robust Platform Q3	Change in Timescale	Develop and implement a secure & robust Platform Q3 – currently on hold due to other priorities and system replacement within Powys Council Social Care Services (procurement complete and contract awarded) - will need to move to 2025/26	ED AHPHS&D	**Yes Q3**
Tackling the Big Four SP 6 Develop and Deliver a Major	Optimal Pathways	6.2) Map and develop key optimal pathways for Diabetes	Change in Executive Lead	Change request to remove DSI&T and transfer to ED PCC&MH.	DSI&T	**Yes Q3**

Conditions Plan						
Tackling the Big Four SP 6 Develop and Deliver a Major Conditions Plan	Diabetes	6.6) Delivery of All Wales Diabetes Prevention Programme (AWDPP) Q1-Q4	Change in Executive Lead	Change request to remove DSI&T as Exec Lead.	DSI&T	**Yes Q3**
Early Help and Support SP 3 Improve Access to Primary and Community Care	Optometry	3.17) Scope Special School Primary Care Eyecare Q1	Change in Scope and Timescale	Special School Primary Care Eyecare (SPEC) is dependent upon national clinical pathways, led by national clinical leads and has been assigned lower priority versus other clinical pathways. Scope of service has not been communicated to HBs so cannot progress this action. No indication this pathway is imminent during 24/25 – request to remove as a key deliverable for 24/25	ED PCC&MH	**Yes Q3**
Transforming in Partnership SP 23 Key Partnerships	Summary provided in this section – refer to the separate Strategy / Plan document of each partnership for further detail	23.1) Summary provided in this section – refer to the separate Strategy / Plan document of each partnership for further detail Q3	Timescale	Timescale change to Q4	ED PH	**Yes Q3**

Transforming in Partnership SP 23 Key Partnerships	PTHB Partnership Assurance and Governance Framework to be developed	23.2) Framework to be developed, agreed and operationalised Q3	Timescale	Timescale change to Q4	DCG/ ED PP&C	**Yes Q3**
Tackling the Big Four SP7 Deliver the Mental Health Transformation Programme	Develop access to provision for sanctuary for adults	7.12) Through collaboration with stakeholders, staff and partners, design a sustainable model for a highly rural setting Q3-4	Timescale	This programme has been suspended due to lack of evidence for rural areas. It is not a current priority for 2024/2025.	ED PCC&MH	
Tackling the Big Four SP7 Deliver the Mental Health Transformation Programme	Take forward the next phase of work to enable access to a step-down solution for those with complex needs	7.15) Continuous engagement Q1-Q4	Timescale	This project was paused on 8th May 2024 and is not a current priority.	ED PCC&MH	
Tackling the Big Four SP7 Deliver the Mental Health Transformation Programme	Take forward the next phase of work to enable access to a step-down solution for those with complex needs	7.16) Explore and develop advisory options appraisal Q1	Timescale	This pro ject was paused on 8th May 2024 and is not a current priority.	ED PCC&MH	
Tackling the Big Four SP7 Deliver the Mental Health	Take forward the next phase of work to enable access to a step-down solution for those with complex needs	7.17) Design and workforce planning Q2	Timescale	This project was paused on 8th May 2024 and is not a current priority.	ED PCC&MH	

Transformation Programme						
Tackling the Big Four SP7 Deliver the Mental Health Transformation Programme	Take forward the next phase of work to enable access to a step-down solution for those with complex needs	7.18) Preparation for procurement Q3-Q4	Timescale	This project was paused on 8th May 2024 and is not a current priority.	ED PCC&MH	
Tackling the Big Four SP7 Deliver the Mental Health Transformation Programme	Develop access to provision for sanctuary for adults	7.12) Through collaboration with stakeholders, staff and partners, design a sustainable model for a highly rural setting Q3-4	Timescale	This programme has been suspended due to lack of evidence for rural areas. It is not a current priority for 2024/2025.	ED PCC&MH	

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 5.4

Delivery and Performance Committee	**Date: 06 February 2025**
Subject:	**Out of Hours General Medical Services Mid-Year Performance 2024/25**
Approved and presented by:	Elaine Lorton, Executive Director of Primary Care, Community and Mental Health
Prepared by:	Assistant Director of Primary Care
Other Committees and meetings considered at:	Executive Committee - 22 January 2025 who took assurance from the report.

PURPOSE:

This paper provides ongoing assurance around the Out of Hours (OOH) General Medical Services (GMS) provision for Powys patients for Q1 and Q2 2024/25.

RECOMMENDATION(S):

The Delivery and Performance Committee is asked to:

- **RECEIVE** the update provided.
- Take **ASSURANCE** that the OOH Commissioning Assurance Framework monitoring process is providing assurance to PTHB on OOH contract management.
- **NOTE** that the Swansea Bay University Health Board weekend pathway continues to follow the weekday pathway.

Approve/Take Assurance	Discuss	Note
Y	Y	Y

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	Y	
2. Provide Early Help and Support	Y	
3. Tackle the Big Four	N	
4. Enable Joined up Care	Y	
5. Develop Workforce Futures	N	
6. Promote Innovative Environments	N	
7. Put Digital First	N	
8. Transforming in Partnership	Y	

EXECUTIVE SUMMARY:

PTHB continues to contract with two providers to deliver its OOH services, Shropdoc Co-operative Ltd and Swansea Bay University Health Board (SBUHB). The OOH pathway is front loaded by the national 111 service.

This paper summarises the performance of the service provided for Quarters 1 and 2, 2024/25. Quarters 3 and 4 will be included in a year end report.

The Revised Standards and Quality Indicators for 111 and Out of Hours Services in Wales (October 2020) are the national metric used to quality measure 111 and OOH services across Wales. The Standards expect a significantly high achievement regarding access timeframes, which are exceptionally difficult to achieve, especially in a rural area.

The PTHB OOH Performance Management Group meets quarterly and monitors the performance management of OOH services for Shropdoc and SBUHB. Commissioning and performance management of the 111 service is undertaken by the NHS Wales Joint Commissioning Committee and reported through the NHS 111 Quality and Delivery Assurance (Commissioning) Framework. The 111 OOH offer to PTHB includes call handling and first line triage only.

PTHB holds a contract with Shropdoc for the provision of OOH GMS and OOH medical cover at PTHB community hospitals, excluding Ystradgynlais. Shropdoc provide PTHB with monthly reports detailing contract achievement against the All-Wales OOH standards. This data, along with other monitoring information, is included in the OOH Commissioning Assurance Framework (CAF) dashboard for Shropdoc. The year end CAF is presented to the Delivery and Performance Committee on an annual basis.

Shropdoc rota shift fill provision during Q1 and Q2 was consistently very good with monthly shift fill rates not falling below 96% (the 2023/24 minimum monthly shift fill was 91%). Unfilled shifts are recorded on the PTHB Datix system. All Shropdoc GPs working PTHB shifts are included on the Powys Medical Performers List.

A summary of disposition rates for Quarter 1 and 2 are as follows:

- 81.6% of patient contacts/outcomes are concluded by Shropdoc assessment and advice. This remains a similar pattern to previous years (82% in 2023/24).
- 2.4% onward referral to 999
- 2.5% advised to attend ED/MIU
- 3.6% referred to a GP (handover of care)
- 4.9% referred to secondary care

An ongoing challenge for Shropdoc is meeting the standard for completing home visits within 1 hour and 2 hours. Due to the geography of Powys the achievement of both these standards will always prove to be challenging. Shropdoc review all breaches to determine the impact to patient care.

The current Shropdoc contract terminates on 31st March 2025. A new short-term contract is being progressed with advice from NHSWSPP Legal and Risk to secure OOH services with Shropdoc until the draft Health Services (Provider Selection Regime) (Wales) Regulations 2025 are laid before the Senedd on 24th February 2025. It is planned that the new regulations once passed will allow PTHB to direct award the continuation of the OOH service with Shropdoc. Due to the tight timescale PTHB will not be able to enact these new regulations and associated requirements by the 31st of March 2025, hence the need for an additional short-term contract to be in place from 1st April 2025.

PTHB commissions an annual contract with SBUHB for the continuation of the OOH service for the Powys Ystradgynlais Medical Practice, including the community hospital. Ystradgynlais patients are seen at SBUHB OOH Centres. SBUHB are unable to offer weekend base cover at Ystradgynlais Community Hospital.

SBUHB reporting on the relevant standard measures for the Powys element of the service is limited due to the inability of extracting Powys specific data; therefore, no data is available regarding assurance around timely patient access for Powys patients. The overall SBUHB shift fill rate is good. SBUHB have not yet committed to sign the 2024/25 contract due to the lack of PTHB OOH District Nursing cover. Options continue to be scoped, and discussions continue.

Historically from a Powys perspective there has been an expectation that the weekend out of hours cover included a GP to be based at Ystradgynlais Community Hospital for a morning session on both a Saturday and Sunday, however this has not been explicit in the contract for a number of years.

Weekend base cover at YCH has not been achieved since the pandemic and the weekend patient pathway follows the weekday OOH pathway, whereby patients registered with Ystradgynlais practice attend a SBUHB base, mainly at Morriston Hospital. Llais are aware of the situation. It is recommended that PTHB confirm to SBUHB that the weekend pathway continues to follow the weekday pathway.

During this reporting period (Q1 and Q2 2024/25) PTHB received no complaints/ concerns relating to OOH services.

BACKGROUND:

Health Boards are responsible for the provision of out of hours general medical services as per the National Health Service (General Medical Services Contracts) (Wales) Regulations 2004.
Out of Hours is defined as:

- 6.30pm to 8.00 am Monday to Thursday
- 6.30pm Friday to 8.00am Monday, and
- all day on public/bank holidays.

PTHB contracts with two providers to deliver its OOH services, namely

- Shropdoc
- Swansea Bay University Health Board (SBUHB)

In addition, the OOH pathway is frontloaded by the national NHS Wales 111 service and is the first point of contact to access PTHB GMS OOH services. The 111 offer to PTHB includes call handling and first line triage only. Patients requiring further clinical triage are passed either to the Shropdoc service, or for Ystradgynlais patients to the SBUHB Clinical Assessment Team and then onto SBUHB OOH service if appropriate.

111 performance management is reported through the NHS Wales Joint Commissioning Committee (JCC) via the NHS 111 Quality and Delivery Assurance (Commissioning) Framework. The Framework ensures NHS 111 Wales provides assurance on the quality of service provided, through the achievement of evidence-based, national delivery standards.

SHROPDOC

PTHB holds a contract with Shropdoc for the provision of Powys Out of Hours General Medical Services (excluding Ystradgynlais patients), Minor Injury Unit cover at Welshpool, Llandrindod Wells and Brecon Community Hospital; and OOH medical cover at PTHB community hospitals (excluding Ystradgynlais Community Hospital).

In addition to this, as part of the contract agreement, Shropdoc also provides PTHB with a service for Care Coordination Centre, Alternative Treatment Scheme, Protected Learning Time cover days and other ad hoc cover required outside of the contract. This paper solely refers to the performance management of the Shropdoc GMS OOH service and not the other services commissioned from Shropdoc.

The current Shropdoc contract terminates on 31st March 2025. A new contract is being progressed to extend the current arrangement from 1st April 2025 to 30th June 2025. It was hoped that a new contract process would not be required and in line with the proposed Health Services (Provider Selection Regime) (Wales) Regulations 2025, PTHB could initiate a Direct Award. The draft Regulations were to be laid before the Senedd on 13 August 2025, however, were withdrawn on 19 September 2025. An updated draft of the regulations has now been laid before the Senedd. Subject to the Senedd's agreement, the draft Health Services (Provider Selection Regime) (Wales) Regulations 2025 will come into force on 24th February 2025. Due to the tight timescale PTHB will not be able to enact these new regulations and associated requirements by the 31st of March 2025. Therefore, the future contract provision is being progressed with NHSWSPP Legal and Risk Services. The PTHB DPCCMH and DOF are jointly leading on this.

SWANSEA BAY UNIVERSITY HEATH BOARD (SBUHB)

PTHB have an annual contract with SBUHB to provide OOH GMS services to Ystradgynlais patients registered with the Ystradgynlais Group Practice and also for OOH medical cover at Ystradgynlais Community Hospital (YCH).

The contract for 2024/2025 has not yet been agreed as there is a fundamental component regarding district nurse provision that requires further consideration. SBUHB require PTHB to put in place district nursing cover during the OOH period to mainly support with catheter management and palliative care support for patients registered with Ystradgynlais Group Medical Practice. The activity relating to both these areas is significantly small and does not justify a PTHB OOH District Nursing Service. The Assistant Director of Community Care Services Group is leading on the discussions with SBUHB District Nursing Service to agree a pathway. Currently SBUHB are not prepared to offer district nursing services to Powys patients. A solution needs to be found for this, in particular for palliative patients.

Historically, from a Powys perspective there has been an expectation that the weekend out of hours cover included a GP to be based at YCH for a morning session on both a Saturday and Sunday, however this has not been explicit in the contract for a number of years and has become an assumed aspiration by PTHB for SBUHB to obtain cover. It is noted that patient activity does not justify a doctor to be based at YCH and would not demonstrate value for money. Weekend base cover at YCH has not been achieved since the pandemic. Previously, the base presence was linked to when an OOH GP was required to undertake a ward round over the weekend period – this is no longer required, and an alternative pathway is in place for weekend medical cover.

From an OOH GMS perspective, default weekend patient pathway is the same as during the weekday OOH period whereby patients registered with Ystradgynlais practice attend a SBUHB base, mainly at Morriston Hospital. Llais are aware of the situation. There have been no patient concerns regarding the weekend OOH access pathway. It is recommended that PTHB confirm to SBUHB that the weekend pathway continues to follow the weekday pathway.

QUARTER 1 & 2 PERFORMANCE AGAINST OOH STANDARDS

The Revised Standards and Quality Indicators for 111 and Out of Hours Services in Wales (October 2020) are the national metrics used to quality measure OOH services across Wales. The Standards expect a significantly high achievement regarding access timeframes, which are exceptionally difficult to achieve, especially in a rural area. Assurance is obtained from breach incident reviews to confirm no patient harm and also patient concerns are used to inform assurance on service delivery.

The standards are split into two separate areas: National Measures (Part A) and Local Measures (Part B). National Measures are public facing and reported to Welsh Government on a monthly basis. The Local Measures are for local reporting purposes only.

The PTHB OOH Performance Management Group, chaired by the Assistant Director of Primary Care, monitors the performance management of OOH services across Powys.

An OOH Commissioning Assurance Framework (CAF) has been in place for a number of years to support the monitoring of OOH services and used as a mechanism to provide assurance to the Board.

- Appendix 1 – Out of Hours Commissioning Assurance Framework Dashboard Mid-Year 2024/2025
- Appendix 2 – Commissioning Assurance Framework
- Appendix 3 - Out of Hours Tolerance Levels

- **Shropdoc**

Shropdoc rota shift fill provision during Q1 and Q2 was consistently very good with monthly shift fill rates not falling below 96% (the 2023/24 minimum monthly shift fill was 91%). Unfilled shifts are recorded on the PTHB Datix system. All Shropdoc GPs working PTHB shifts are included on the Powys Medical Performers List.

Shropdoc provide PTHB with monthly reports detailing contract achievement against the All-Wales OOH standards (Local and National Measures) and also a quarterly view is analysed by the OOH Performance Management Group.

An ongoing challenge for Shropdoc is meeting the home visiting requirement, in particular home visits required to take place within 1 hour and 2 hours. Due to the geography of Powys and the OOH resources at the defined bases the achievement of both these standards will always prove to be challenging.

Shropdoc provide assurance through analysis of breaches against the standards. When reviewing and investigating breaches and incidents, Shropdoc considers two main questions:

- *Where an incident occurs, is it related to a breached case and did the delay contribute to the incident or produce harm to the patient?*
- *How is it known whether a breached triage consultation, base visit or home visit resulted in harm, when the case has not been highlighted to Shropdoc's Quality system*?

All breaches resulting in an incident are investigated and learning from events are shared with clinicians for reflection and action learning. The investigative process concludes with recommendations for: change in process; communication; education; and quality improvement.

Shropdoc patient outcome/disposition April to September 2024:

Advised to attend ED/MIU	176	2.48%
Assessment and advice	5790	81.63%
Death	111	1.56%
Dental	0	0.00%
Failed contact	49	0.69%
Referred to 999	173	2.44%
Referred to a General Practitioner (handover of care)	256	3.61%
Referred to another Health Professional	28	0.39%
Referred to Mental Health Team	0	0.00%
Referred to Secondary Care	352	4.96%
Referred to Social Services	0	0.00%
No outcome recorded	158	2.23%

Additional Shropdoc assurance includes:

- Clinical governance assurance framework in place
- Adherence to alert letters – confirming that alert letter are appropriately actioned
- Clinical risk – risk register and risk management processes in place with clear accountability
- Incidents – 100% of reporting serious incidents is within agreed timescales. All incidents are reviewed, investigated and used as 'learning events'.
- 111 Health Profession Feedback – good communication channels are in place between Shropdoc and 111 to resolve issues.
- Safeguarding – in conjunction with PTHB Safeguarding team and General Practice, at-risk patients are notified to Shropdoc
- Clinical Audit undertaken against the RCGP OOHs toolkit criteria to review 1% of cases on a monthly basis.
- Prescribing formulary in place
- Patient surveys are undertaken, and evidence of service user experience is used to drive improvement.

Concerns and Compliments received by Shropdoc (Q1 and Q2 2024/25):

- Compliments – 4 received
- Concerns – 1 received, further detail below. All concerns are responded to promptly and within agreed time limits.

Ref:	Description:	Outcome:
1 (Q1)	Prescription sent to the wrong pharmacy. Resolved with patient receiving the prescription the same day.	No patient harm

Shift Fill:

Triage and base shift cover rate for Shropdoc continues to be very good and achieved 96% to 100% of Level 1 cover (90% - 100% shift fill) for Q1 and Q2.

Month	% Filled shifts
April	99
May	99
June	99
July	96
August	99
September	98

Base shifts not filled are cross covered from the neighbouring base. Additional triage hours are often put on at the Shropdoc triage hub to further support base activity.

Shropdoc notify PTHB every Friday, the cover for the forthcoming weekend, and continue to source cover up until a shift commences. In addition to this they provide regular in week rota cover updates which aids further assurance of immediate rota gaps. Shropdoc utilise resources from other areas (sometimes cross border) when necessary to support the Powys service. Weekend rota fill is shared with the PTHB GOLD Executive on call rota

Unfilled shifts are recorded on the PTHB Datix system.

All Shropdoc GPs working PTHB shifts are included on the Powys Medical Performers List. There is approximately a total of 180 GPs supporting the Powys shifts, compared to 60 in 2023/24.

- **Swansea Bay University Health Board**

Reporting on the relevant standard measures for the Powys element of the service is limited due to the inability of SBUHB being able to extract Powys specific data; therefore, monitoring the service against the standards is currently not achievable. SBUHB are only able to quantify the number of Ystradgynlais patients accessing the service and the patient outcomes/management (see table below). There is no data available regarding assurance around timely patient access against the OOH standards.

	Patients of Ystradgynlais Group Practice Patient Outcome/Management April to September 2024					
Month	**Contact First**	**Doctor Advice**	**Home Visit**	**Prescription Pickup**	**Treatment Centre**	**Total per month**

Apr-24	7	59	5	11	41	**123**
May-24	3	67	4	7	48	**129**
Jun-24	3	56	8	5	42	**114**
Jul-24	5	44	5	5	37	**96**
Aug-24	10	48	7	8	38	**111**
Sep-24	11	57	8	8	48	**132**
					TOTAL	**705**

Shift fill:
Patients access SBUHB Primary Care Centres, mainly at Morriston Hospital, noting the comment above regarding YCH base sessions.

SBUHB keep PTHB up to date on shift fill throughout the week and in particular on a Friday for the weekend and continue to source cover up until a shift commences. The majority of SBUHB shift cover during the period has been at level 1 (90% to 100%), noting this does not include base cover at YCH (as per comment above). Unfilled shifts are recorded on the PTHB Datix system.

During this reporting period no patient concerns have been raised regarding access.

PTHB OOH Concerns

During this reporting period, PTHB received no concerns relating to OOH services with Shropdoc and SBUHB

NEXT STEPS:

1) Continue to monitor the OOH contracts through the OOH CAF for future reporting on OOH Performance until the PTHB Performance Dashboard is implemented.
2) Ensure appropriate contractual mechanism is in place from 1st April 2025
3) Progress agreement for OOH contract for the Ystradgynlais area.
4) Prepare a 2024/25 end of Year report to provide ongoing assurance

Appendix 1 – Out of Hours Commissioning Assurance Framework Dashboard Q1 and Q2 2024/25
Appendix 2 – Commissioning Assurance Framework
Appendix 3 - Out of Hours Tolerance Levels

IMPACT ASSESSMENT

This section must be completed for all strategic organisational decisions including approval of health board policies.

QUALITY:

	No impact	Negative	Positive	Both	
Safe			X		A Quality Impact Assessment must be undertaken for all reports requesting approval, ratification or decision in line with health board Duty of Quality processes (under development). In this space you should provide supporting narrative to explain the potential adverse and positive impacts that may arise from a decision being taken, and the steps being taken to mitigate adverse impacts. Where required, the full Quality Impact Assessment should be available as a supporting document to inform the decision making process.
Timely			X		
Effective			X		
Efficient			X		
Equitable			X		
Person Centred			X		
Workforce			X		
Leadership	X				
Culture	X				
Information			X		
Learn, Improve, Research	X				
Whole Systems Approach	X				

EQUALITY:

	No impact	Negative	Positive	Both	
Age	X				An Equality Impact Assessment must be undertaken for all reports requesting approval, ratification or decision in line with health board Equality Impact Assessment policies and procedures (CGP009). In this space you should provide supporting narrative to explain the potential adverse and positive impacts that may arise from a decision being taken, and the steps being taken to mitigate adverse impacts. Where required, the full Equality Impact Assessment should be available as a supporting document to inform the decision making process.
Disability	X				
Gender reassignment	X				
Marriage / civil partnership	X				
Pregnancy / maternity	X				
Race	X				
Religion or Belief	X				
Gender	X				
Sexual Orientation	X				
Welsh Language	X				
Socio-economic status	X				
Social exclusion	X				
Carers	X				

RISK ASSESSMENT:

	Level of risk identified				
	Very Low (0-3)	Low (4-8)	Moderate (9-12)	High (15-25)	A Risk Assessment should be undertaken for all reports requesting approval, ratification or decision in line with health board Risk Management Framework CGP005. In this space you should briefly describe the key risks and the steps being taken to manage them, and also how these risks relate to the Board's stated Risk Appetite.
Clinical		x			
Financial		X			
Corporate		X			
Operational		X			
Reputational		X			

A CONTRACT															
Signed contract in place		Yes													
Duration of contract		1st July 2022 to 31st March 2025													
Times of the Out of Hours services		6.30pm to 8am Mondays to Thursdays, 6.30pm Friday to 8am Monday and all day Public/Bank Holidays													
Primary Care Centre locations		Brecon	Llandrindod Wells	Newtown - up to midnight	Welshpool - after midnight										
Locations where Community Hospital Services are provided		Brecon	Llandrindod Wells	Newtown	Welshpool	Llanidloes	Builth Wells	Knighton	Bronllys						
Description of Community Hospital Services provided		Inpatients and Minor Injuries Unit	Inpatients and Minor Injuries Unit	Inpatients	Inpatients and Minor Injuries Unit	Inpatients	Inpatients	Inpatients	Inpatients						
Margin cover provided to GP Practices (8am to 8.30am and/or 6pm to 6.30pm)		13 Practices													
B QUALITY AND SAFETY															
		apr-24		**mai-24**		**jun-24**		**jul-24**		**aug-24**		**sep-24**		**Total**	**% in time**
Of the total number of calls answered by the Shropdoc call handler, how many patient contacts were prioritised as P1CT and started their definitive clinical asssessment	In 60 minutes (1 hour) or less of the initial call being completed. *Target 90%*	654	86 %	659	86 %	610	88 %	533	91 %	620	92 %	528	87 %	3604	88 %
	Over 60 minutes (1 hour) and up to and including 360 minutes (6 hours) of the initial call being completed	102		108		80		53		52		81		476	
	Over 360 minutes (6 hours) of the initial call being completed	1		1		0		0		0		0		2	
	Total number of patient contacts recorded where the initial call was prioritised as P1CT	**757**		**768**		**690**		**586**		**672**		**609**		4 082	
***Median time for patients prioritised as PICT** to start their clinical assessment*		18,77		23,02		18,61		17,54		17,38		20,95			
Of the total number of calls answered by the Shropdoc call handler, how many patient contacts were prioritised as P2CT and started their definitive clinical assessment:	In 120 minutes (2 hours) or less of the initial call being completed *Target 90%.*	288	88 %	277	88 %	287	89 %	258	93 %	284	94 %	232	89,6%		0 %
	Over 120 minutes (2 hours) and up to and including 360 minutes (6 hours) of the initial call being completed	38		37		37		18		18		26			
	Over 360 minutes (6 hours) of the initial call being completed	3		0		0		0		0		1			
	Total number of patient contacts recorded where the initial call was prioritised as P2CT	**329**		**314**		**324**		**276**		**302**		**259**		1804	
***Median time for patients prioritised as P2CT** to start their clinical assessment*		43,08		33,51		29,35		25,41		20,28		32,1			
Of the total number of calls answered by the Shropdoc call handler, how many patient contacts were prioritised as P3CT and started their definitive clinical assessment:	In 240 minutes (4 hours) or less of the initial call being completed *Target 90%.*	121	83 %	192	88 %	206	92 %	159	96 %	256	97 %	168	89 %	1102	91 %
	Over 240 minutes (4 hours) and up to and including 360 minutes (6 hours) of the initial call being completed	13		24		9		6		9		19		80	
	Over 360 minutes (6 hours) of the initial call being completed	12		2		9		1		0		1		25	
	Total number of patient contacts recorded where the initial call was prioritised as P3CT	**146**		**218**		**224**		**166**		**265**		**188**		1207	
***Median time for patients prioritised as P3CT** to start their clinical assessment*		86,84		60,02		52,76		31,81		42,15		49,43			
Total number of patient contacts recorded where the patient was referred for a Primary Care Centre (PCC) appointment following direct streaming by the Shropdoc call handler		**426**		**425**		**407**		**325**		**376**		**328**		**2287**	
Total number of patient contacts recorded where the patient required a home visit following direct streaming by the Shropdoc call handler		**195**		**211**		**178**		**156**		**192**		**186**		1118	
Total number of patient contacts recorded where the patient did not have a definitive clinical assessment undertaken by a Shropdoc clinician (e.g. in the case of a patient who has been transferred from an A&E department / MIU, walk-in patients and where the patient was given information only by the call handler)		**0**		**0**		**0**		**0**		**0**		**0**		0	
Total number of patient contacts recorded during the month		**1853**		**1936**		**1823**		**1509**		**1807**		**1570**		**10498**	
Of the total number of patient contacts that were referred to or remained in a Primary Care Centre (PCC) following either: • their definitive clinical assessment; or • face to face triage (in the case of walk-in patients), how many were prioritised as P1F2F and seen:	In 60 minutes (1 hour) or less following completion of definitive clinical assessment / face to face triage *Target 90%*	6	75 %	6	55 %	0	100 %	0	0 %	3	100 %	1	50 %	16	64 %
	Over 60 minutes (1 hour) and up to and including 480 minutes (8 hours) following completion of definitive clinical assessment / face	2		5		0		1		0		1		9	
	Over 480 minutes (8 hours) following completion of definitive clinical assessment / face to face triage	0		0		0		0		0		0		0	
	Total number of patient contacts that were referred to a PCC and were prioritised as P1F2F following their clinical assessment / face to face triage	**8**		**11**		**0**		**1**		**3**		**2**		25	
Median time for patients prioritised as P1F2F to be seen by a clinician at a Primary Care Centre (PCC)		28,53		50,07		n/a		119,53		41,05		51,36			
Of the total number of patient contacts that were referred to or remained in a Primary Care Centre (PCC) following either: • their definitive clinical assessment; or • face to face triage (in the case of walk-in patients), how many were prioritised as P2F2F and seen:	In 120 minutes (2 hours) or less following completion of definitive clinical assessment / face to face triage *Target 90%.*	75	82 %	51	73 %	38	81 %	38	84 %	27	90 %	44	88 %	273	82 %
	Over 120 minutes (2 hours) and up to and including 480 minutes (8 hours) following completion of definitive clinical assessment / face	16		19		9		7		3		6		60	
	Over 480 minutes (8 hours) following completion of definitive clinical assessment / face to face triage	1		0		0		0		0		0		1	
	Total number of patient contacts that were referred to a PCC and were prioritised as P2F2F following their clinical assessment / face to face triage	**92**		**70**		**47**		**45**		**30**		**50**		334	
Median time for patients prioritised as P2F2F to be seen by a clinician at a Primary Care Centre (PCC)		51,02		65,2		41,72		47,33		59,99		49,67			
Of the total number of patient contacts that were referred to or remained in a Primary Care Centre (PCC) following either: • their definitive clinical assessment; or • face to face triage (in the case of walk-in patients), how many were prioritised as P3F2F and seen:	In 480 minutes (8 hours) or less following completion of definitive clinical assessment / face to face triage *Target 90%.*	308	94 %	320	93 %	346	96 %	272	97 %	331	97 %	263	95 %	1840	95 %
	Over 480 minutes (8 hours) following completion of definitive clinical assessment / face to face triage	18		24		14		7		12		13		88	
	Total number of patient contacts that were referred to a PCC and were prioritised as P3F2F following their clinical assessment / face to face triage	**326**		**344**		**360**		**279**		**343**		**276**		1928	
Median time for patients prioritised as P3F2F to be seen by a clinician at a Primary Care Centre (PCC)		67,65		77,18		65,04		61,8		55,03		63,6			
Of the total number of patient contacts that were referred to or remained in a Primary Care Centre (PCC) how many were not prioritised before being seen (due to no definitive clinical assessment being recorded) or were not seen (due to the patient not attending or cancelling their appointment)		**0**		**0**		**0**		**0**		**0**		**0**		0	
Of the total number of patient contacts that required a home visit following their definitive clinical assessment, how many were prioritised as P1F2F and seen:	In 60 minutes (1 hour) or less following completion of definitive clinical assessment *Target 90%.*	6	55 %	6	55 %	5	83 %	9	69 %	9	82 %	10	83 %	45	70 %
	Over 60 minutes (1 hour) and up to and including 480 minutes (8 hours) following completion of definitive clinical assessment	5		5		1		4		2		2		19	
	Over 480 minutes (8 hours) following completion of definitive clinical assessment	0		0		0		0		0		0		0	
	Total number of patient contacts that required a home visit and were prioritised as P1F2F following their clinical assessment	**11**		**11**		**6**		**13**		**11**		**12**		64	
Median time of patients prioritised as P1F2F requiring a Home Visit to be seen as soon as possible following completion of their definitive clinical assessment		57,23		53,7		36,43		50,98		42,5		33,82			
Of the total number of patient contacts that required a home visit following their definitive clinical assessment, how many were prioritised as P2F2F and seen:	In 120 minutes (2 hours) or less following completion of definitive clinical assessment *Target 90%.*	58	88 %	53	84 %	48	86 %	33	73 %	46	88 %	50	85 %	288	84 %
	Over 120 minutes (2 hours) and up to and including 480 minutes (8 hours) following completion of definitive clinical assessment	8		10		8		12		6		9		53	
	Over 480 minutes (8 hours) following completion of definitive clinical assessment	0		0		0		0		0		0		0	
	Total number of patient contacts that required a home visit and were prioritised as P2F2F following their clinical assessment	**66**		**63**		**56**		**45**		**52**		**59**		341	
Median time of patients prioritised as P2F2F requiring a Home Visit to be seen as soon as possible following		71,91		76,7		56,87		67,42		56,33		54,92			
Of the total number of patient contacts that required a home visit following their definitive clinical assessment, how many were prioritised as P3F2F and seen:	In 480 minutes (8 hours) or less following completion of definitive clinical assessment *Target 90%.*	116	98 %	136	99 %	116	100 %	97	99 %	129	100 %	113	98 %	707	99 %
	Over 480 minutes (8 hours) following completion of definitive clinical assessment	2		1		0		1		0		2		6	
	Total number of patient contacts that required a home visit and were prioritised as P3F2F following their clinical assessment	**118**		**137**		**116**		**98**		**129**		**115**		713	
Median time of patients prioritised as P3F2F requiring a Home Visit to be seen as soon as possible following		84,64		97,72		64,09		8171		80,65		71,68			
Off the total number of face-to-face appointments (Primary Care Centre and Home Visits) (P1F2F, F2F2F and P3F2F), how many were seen within 8 hours following completion of their definitive clinical assessment. *Target 99%*		97 %		96 %		98 %		98 %		98 %		97 %			
Of the total number of patient contacts that required a home visit how many were not prioritised before their home visit (due to no definitive clinical assessment being recorded) or were not seen (due to the patient not being at home or cancelling their home visit)		0		**0**		**0**		**0**		**0**		**0**		0	
Total number of patient contacts that required a home visit following their definitive clinical assessment		**195**		**211**		**178**		**156**		**192**		**186**			
Of the total number of patient contacts recorded*, what was the primary outcome for the patient: *This is the total number of patients. The number differs from the total number of patient contacts recorded (above) as all patients are initially contacted by phone and some are then seen at the Primary Care Centre or Home Visit which is then recorded as another contact.	Administration	0	0 %	0	0 %	0	0 %	0	0 %	0	0 %	0	0 %	0	0,00 %
	Advised to attend ED/MIU	27	2 %	28	2 %	31	3 %	21	2 %	34	3 %	35	3 %	176	2,48 %
	Advised to contact another Health Professional	0	0 %	0	0 %	0	0 %	0	0 %	0	0 %	0	0 %	0	0,00 %
	Advised to contact General Practice	0	0 %	0	0 %	0	0 %	0	0 %	0	0 %	0	0 %	0	0,00 %
	Assessment and advice	1004	81 %	1060	82 %	1012	82 %	842	82 %	1025	83 %	847	80 %	5790	81,63 %
	Death	18	1 %	26	2 %	23	2 %	16	2 %	15	1 %	13	1 %	111	1,56 %
	Dental	0	0 %	0	0 %	0	0 %	0	0 %	0	0 %	0	0 %	0	0,00 %
	Failed contact	9	1 %	5	0 %	13	1 %	8	1 %	7	1 %	7	1 %	49	0,69 %
	Health information / quick call	0	0 %	0	0 %	0	0 %	0	0 %	0	0 %	0	0 %	0	0,00 %
	Referred to 999	27	2 %	37	3 %	28	2 %	19	2 %	28	2 %	34	3 %	173	2,44 %
	Referred to a General Practitioner (handover of care)	52	4 %	43	3 %	42	3 %	45	4 %	42	3 %	32	3 %	256	3,61 %
	Referred to another Health Professional	4	0 %	5	0 %	7	1 %	2	0 %	4	0 %	6	1 %	28	0,39 %
	Referred to Mental Health Team	0	0 %	0	0 %	0	0 %	0	0 %	0	0 %	0	0 %	0	0,00 %
	Referred to Secondary Care	67	5 %	73	6 %	52	4 %	48	5 %	55	4 %	57	5 %	352	4,96 %
	Referred to Social Services	0	0 %	0	0 %	0	0 %	0	0 %	0	0 %	0	0 %	0	0,00 %
	No outcome recorded	24	2 %	23	2 %	30	2 %	27	3 %	29	2 %	25	2 %	158	2,23 %
		1232		1300		1238		1028		1239		1056		7093	
		apr-24		**mai-24**		**jun-24**		**jul-24**		**aug-24**		**sep-24**			
Triage and shift fill. Percentage of shift hours filled. (Based on 90%+ cover)		99 %		99 %		99 %		96 %		99 %		98 %			
Clinical governance assurance framework in place		Yes													
Adherence to alert letters - Clinical Governance requirements (confirmation that alert letters are appropriately actioned).		Yes													
Number of incidents.		48													
Undertake review of DATIX and serious incidents including themes		Yes													
100% reporting of serious incidents to PTHB in agreed timescale		Yes													
Undertake Clinical Audit using RCGP toolkit, or other appropriate tools, to review 1% of cases on a monthly basis. Audit should include end to end review of the patient's journey through 111 to points of care		Yes													
Clinical audit to be undertaken to learn from serious incidents and demonstrate quality improvement has been adopted, and that reporting is in line with guidance		Yes													
Prescribing formulary in place - i.e. Antibiotics = clinical review of cases - in line with clinical governance requirments. Activity data on prescribing practice.		Yes													
Risk management in place with clear accountability - evidence of an active and appropriate risk log and management action - quarterly		Yes													
Up-to-date Business Continuity Plan in place and regularly reviewed.		Yes													
C ACCESS															
Ensure the service compiles with All Wales standards for equality.		Yes													
D PATIENT EXPERIENCE															
Compliments, concerns and complaints are responded to promptly and within agreed time limits (25 days agreed)		Yes													
Number of complaints and concerns received by Shropdoc		1													
Number of compliments received by Shropdoc		3													
Number of complaints and concerns received by PTHB		0													
Number of complaints and concerns received by Llais		0													
Gather and use evidence of service user experience to drive improvement - patient survey undertaken during CAF reporting period		Yes													

Primary Care - Out of Hours

Commissioning Assurance Framework

This framework describes a continuous assurance process that aims to provide confidence to internal and external stakeholders and the wider public that PTHB are operating effectively to commission safe, high-quality and sustainable services within their resources, delivering on their statutory duties and driving continuous improvement in the quality of services and outcomes achieved for patients.

Version 3

Revised: May 2024

Review Date: May 2025

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1. Introduction

This Commissioning Assurance Framework for Primary Care Out of Hours describes a continuous assurance process that aims to provide confidence to internal and external stakeholders and the wider public that PTHB is operating effectively to commission safe, high-quality and sustainable services within the resources available, delivering on statutory duties and driving continuous improvement in the quality of services and outcomes achieved for patients. Once agreed, this framework will be subject to a 12 month review.

PTHB aims to commission services that improve the health and wellbeing of the people of Powys. Commissioning is simply how we plan, agree and monitor the health services needed. We will do this by securing sustainable care that enables patients to receive modern, responsive, high quality yet cost effective care and services that are effectively commissioned within PTHB's financial resource limits.

Powys Teaching Health Board is primarily a commissioning organisation. The largest proportion of its budget is devoted to securing health care services including unscheduled and planned care from neighbouring health boards and NHS Trusts. A significant proportion of the budget is devoted to primary care services to secure health care provision for general medical services, Out of Hours, general dental services, general optometric services, and community pharmacy services. PTHB, along with patients, the public and fellow commissioners, needs to be assured that we are able to demonstrate the effective use of public funds in commissioning safe, high quality and sustainable services within available resources.

Quality in Powys is everybody's business with ownership and understanding of both the challenges and the solutions shared across all organisations, professions and with the public. Our approach places quality at the heart of our work, ensuring we monitor, and make efforts to improve, the quality of healthcare we commission. Our aim is to ensure that together we drive up the quality of care and treatment of services provided for the people of Powys, and that there continues to be a culture of continuous quality improvement.

As a Health Board we need to ensure that we are delivering services that meet patient needs, and performance management gives us a way of making decisions about where to focus resources depending on needs at any one time. Over time, performance management allows relative measurement to be made so that we can see if improvements are being made and if extra efforts need to be made in particular areas to achieve those improvements. We also need to ensure that we provide effective and robust monitoring arrangements to ensure performance, quality and efficiency of all services delivered on our behalf. This framework describes PTHB's approach to commissioning assurance. It provides an overview of:

- The principles and behaviours which will underpin the approach to assurance;
- The contents of the assurance framework;
- How the assurance process will operate; and,
- PTHB's potential responses to the assurance process.

2. Background

Within Powys we have had to respond to more challenging performance and financial positions, as well as changes within the commissioning landscape. The lessons for future commissioning from The Francis Report 2013 are that commissioners have a critical role in driving quality. We will need to agree standards above those set by the Healthcare Inspectorate Wales (HIW), with the aim of driving improvement, and setting out longer term goals with all providers by way of

developmental standards and focus on improvements in effectiveness ensuring that our patients are the first and foremost consideration, and to ensure services commissioned by PTHB secure a consistent culture of care with patient's interest at the very heart.

This quality assurance framework will set out how we monitor and performance manage the quality of care we commission - including the crucial ability to recognise early and act on any systematic deterioration in care within a provider organisation.

3. Scope of the Commissioning Assurance Framework

The assurance process is a more risk-based approach which differentiates high performing Providers, those whose performance gives cause for concern, and those in between. It provides a robust, supportive and structured framework for those in more challenged circumstances, with a lighter touch approach for the best performers.

A continuous assurance approach helps to identify emerging patterns of poor performance or any areas of potential risk, with less reliance on fixed points. The process uses information derived from a variety of sources including, where necessary, face-to-face visits. The nature of the oversight, including the expected frequency of assurance meetings is dependent on the circumstances, the range of risks identified, and on the leadership response. The assurance framework recognises that assurance is a continuous process that considers the breadth of a Health Board's responsibilities.

It consists of the following five key areas:

- ✓ **Access to Care** - the timely access to health services to achieve the best health outcomes for patients
- ✓ **Quality and Safety** - ensure that services being commissioned are safe, personal, effective and continuously improving;
- ✓ **Finance & Activity** – patterns and variation from the planned level of activity or a variation in cost that indicates higher/lower target performance;
- ✓ **Patient Experience** - use patient and carer feedback, along with complaints and concerns raised with the THB, to strengthen our ability to detect early warning signs of deterioration in quality, as well as evidence of excellence that should be adopted and spread;
- ✓ **Governance and strategic change** – covers the degree of government or regulator intervention and sustainability (planned and unplanned service changes).

A set of broad principles has been identified, which should underpin how our commissioning assurance is undertaken:

- Assurance should be transparent and demonstrate to internal and external stakeholders and the wider public the effective use of public funds to commission safe and sustainable services.
- Assurance is primarily about providing confidence.
- Assurance should build on what we are already doing to hold ourselves accountable locally to communities and stakeholders, for both statutory requirements and for national and local priorities.
- Assurance should minimise bureaucracy and additional reporting requirements by drawing on available data and aligning with other regulatory and planning processes – there should be minimal additional paperwork.
- Assurance should be proportionate and respect the time and priorities of PTHB and our Providers.
- Assurance should be summative and take place over the year as on-going conversations.

- Assurance processes should be able to swiftly identify performance outside pre-set tolerances.
- The tone, process and outcomes need to focus on development as well as performance.
- Accountability, learning and development will be integral to the process.
- Whilst uncompromising on the facts which describe the quality of services patients are receiving, we will be open minded in understanding the reasons for variation and, where a problem is found, clear on the consequences and actions we will need to take.

4. Components of the Commissioning Assurance Framework

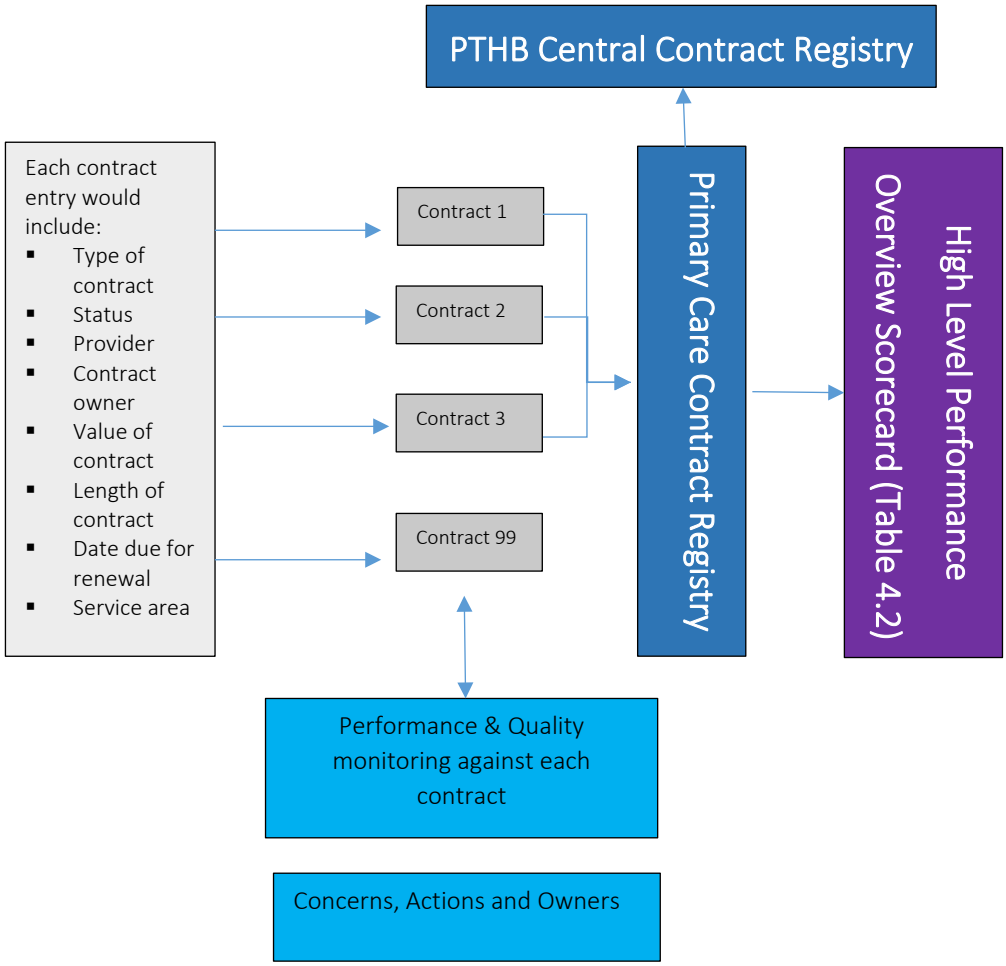
Out of Hours contracts between health boards and Out of Hours service providers are delivered within the regulations set out in its statutory duty under Sections 41(1) and 41(2)(b) of the National Health Service (Wales) Act 2006 to secure primary medical services within its area. PTHB's appointed Contractors to provide Out of Hours Medical Services and other services in accordance with the provisions of the National Health Service (Wales) Act 2006 are 111 NHS Wales, Shropshire Doctors' Co-operative Limited (Shropdoc) and Swansea Bay University Health Board.

4.1 Register of Providers

Where Powys Teaching Health Board (PTHB) is the commissioner the principles of good contract management remain an important part of the wider commissioning process. It is about more than ensuring providers meet their agreed obligations. It can help PTHB to identify and manage its own and provider risks, demonstrate value for money, potentially achieve savings and continuous improvement.

It means understanding what the contract contains, who has responsibility for managing it, and whether performance and costs are on track. The best result are achieved when those who are involved in commissioning and running the service work together to manage the agreement and have clear agreed processes and procedures in place to help them do so.

A "register" of primary care Out of Hours contracts will be held within the Primary Care Team and will include all Out of Hour contracts and agreements issued for primary Out of Hours services within PTHB. This " register" will feed into the central "register".



4.2 Levels of Assurance

The prioritisation mechanisms for quality assurance that we will utilise are as follows:

Green	On target. The number of milestones met greater than number of milestones not yet met (with no significant outliers)	Routine Monitoring - Evidence and data will be provided through the Quality Schedules and/or information from national assessments and usual data sources
Amber	Risk to delivery (number of milestones met equals milestones not met) Missing objective/target but on agreed performance improvement trajectory	Enhanced monitoring via an exception report and associated remedial actions and trajectory for improvement
Red	Not on target Number of milestones not met is greater than those met Persistently not meeting threshold (3 months); and highly unlikely to achieve recovery within specified period	Escalated performance monitoring requiring detailed action plan and agreed as minimum monthly (in some cases fortnightly) reviews where commissioners have serious concerns about contract delivery, quality and patient safety

Table 4.1 Levels of Assurance

The Health Board's Performance Management Framework uses a red / amber / green system to facilitate the appropriate prioritisation and escalation of performance issues. The rating system for providers will utilise the same level of assurance.

Tolerances may be agreed by the Executive Committee, for example, in relation to financial performance.

4.3 Developing and Implementing a Rating System for Providers

As a Health Board we need to provide effective and robust monitoring arrangements to ensure performance, quality and efficiency of all services delivered on our behalf. We will have in place systems and processes for anticipating and responding to performance trajectories and risk assessments include measures of safety, effectiveness and user experience. There is strong evidence to suggest a rating should be based on a combination of indicators compiled from routinely available data, and information from inspections and patient experience and not just data alone.

Each provider will be rated to help PTHB compare services and to highlight where care is good or outstanding and expose where care is inadequate or requires improvement. We will use the following categories for assessment; Access – Scheduled and Unscheduled Care, Quality & Safety, Patients Experience and Finance (Activity & Cost). Information is also collected in relation to Governance and Strategic change. The PTHB scoring system is used in addition to help provide assurance within the Health Board in relation to the services provided to its residents. This will be displayed in a high level dashboard to show at a glance the provider rating. (Arrows will be used to indicate the direction of monthly changes.) Absence of required information will be recorded and the score will reflect whether there is an agreed development plan to provide such information.

Provider	Date	G Y A1 A2 R Performance Framework Rating Assessment				
		Access	Finance & Activity	Quality & Safety	Patient Experience	Overall Rating
1	Sep 18					Level 1
2	Sep 18					Level 1
2	Sep 18					Level 2
3	Sep 18					Level 3R
4	Sep 18					Level 4
5	Sep 18					level 4+

Table 4.2 High Level Performance Overview Scorecard

4.4 Internal Commissioning Assurance incorporated as part of the out of Hours Contract Monitoring Group

Internal Commissioning Assurance is delivered through the Out of Hours Quarterly Performance Management Group which provide the opportunity for key people to meet on a quarterly basis to look at out of hours data. The meeting will usually comprise representatives from the OOH providers primary care and finance who consider and review key information relating to each of the out of hours providers within Powys.

The data and discussion enables PTHB to form conclusions on whether there are any areas of concern and whether to 'step up' or 'step down' **Escalation Process** (see Section 4.6). This provides us with a mechanism for monitoring and follow-up which can then be used to strengthen our assurance and enables us to show how we are using the data to improve patient outcomes.

Key data is captured on each contractor and records exceptions and key trends drawn from for example:

Quality & Safety	Finance (Cost & Activity)	Access	Patient Experience
▪ Standards and quality indicators – 111 and OOH in Wales - National and Local Measures* ▪ OOH quarterly reports ▪ Shift fill and rota cover* ▪ Clinical governance framework ▪ DATIX and serious incidents (including themes) ▪ Clinical Audits ▪ Prescribing formulary ▪ Risk management	▪ Signed contract ▪ Contract Value ▪ Times of service provision ▪ Locations of services	▪ Standards and quality Indicators- 111 and OOH in Wales- National and Local Measures* ▪ Shift Fill and Rota Cover* ▪ All-Wales equality standards	▪ Llais Reports ▪ Complaints, concerns and compliments from any source ▪ Patient experience performance, e.g. surveys
Sustainability Status			

* These indicators bridge both Access and Quality and Safety.

4.5 Contract Quality Review & Performance Management

The quarterly reports received from the out of hours providers will support the Out of Hours Performance Management Group. The service providers will also meet with the PTHB primary care team, Llais and the medical director or their deputy on a quarterly basis to discuss the submitted reports. There is also an end of year annual performance review meeting with each provider.

Assurance on compliance will be sought and information reviewed in line with the contract requirements as stated in each individual provider contract and determined by the Out of Hours standards and Quality Indicators both National and local as set out by Welsh Government. These processes will be led and co-ordinated by the Primary Care Team and Out of Hours Performance Management Group.

A critical gap in the system of oversight of quality and safety was identified in the Francis report, which arose from the inability of commissioners to collect information on provider quality and to understand and make use of the contractual mechanisms that were available to them. PTHB recognises the importance of information and an understanding of how to act on it, and will use contractual mechanisms such as audit, inspection, and investigation to understand quality in Out of Hours services. Where possible the triangulation of data relating to patient safety and quality of care will be undertaken. In addition, analysis of the concerns process and patient experience mechanisms will be utilised to evaluate impact on quality and patient safety.

A regular assessment of the provider escalation level will take place during the Out of Hours Performance Management Group meeting in line with the escalation process set out below. The retention of contract monitoring records will be kept within the PTHB Primary Care Department.

4.6 Escalation Process for Providers

This Framework sets clear thresholds for intervention in underperforming providers and a rules-based process for escalation. Provider performance is assessed against a series of indicators using the most current data available, and the results will trigger intervention by commissioners in the case of performance concerns, where the escalation process will be a 'step-up, step-down' process. There will be a proportionate approach which takes into account the degree of risk for Powys residents.

	Level of Monitoring	Escalation	Monitoring Meeting Frequency
Level 1 Green	Routine Monitoring - Evidence and data will be provided through the Quality Schedules and/or information from national assessments and usual data sources	None - Routine monitoring	Continuous process Quarterly formal Routine Monitoring, Weekly rota monitoring. (Which is escalated accordingly)
Level 2 Amber	Enhanced monitoring via exception and associated remedial actions and trajectory for improvement includes Out of Hours Performance Management Group Meeting	Enhanced monitoring	Bi- monthly – Enhanced Monitoring
Level 3 Red	One Red area Escalated performance monitoring requiring detailed action plans for exceptions	If Contractual/regulation breach, escalated to DPCCMH and reported to Delivery & Performance Group	Quarterly – Enhanced Monitoring DPCCMH to receive papers and attend and if appropriate attend Contractor Review Meeting if required
Level 4 Red +	Two or more Red areas Chief Exec made aware – Provider meeting may be arranged Escalated performance monitoring requiring detailed action plan for exceptions and agreed as minimum monthly (in some cases fortnightly) reviews where commissioners have serious concerns about quality and patient safety	If Contractual/regulation breach, escalated and *Reported to Finance & Performance Committee*	quarterly – Escalated Monitoring CEO/ DPCCMH led escalated meetings if there are significant and persistent concerns (supported

Table 4.3 Escalation Table

Reasons for Escalation include:

- Any issues that present an immediate challenge to service continuity, which may affect the reputation of the commissioner and/or the provider and could result in any closure or partial closure of a service;
- Alarms or concerns arising from the examination of qualitative and quantitative data.
- Alternatively, a worrying set of workforce metrics or credible soft intelligence which is not readily accounted for by the provider.
- When a concern about quality has been identified and acknowledged by the provider and commissioner but where the mitigating actions to improve the situation are showing little signs of having an impact and patients continue to be at risk, or potentially at risk;
- Repeated failure to deliver agreed improvement plans;
- Evident or suspected poor leadership and/ or governance, particularly clinical governance;
- Serious media exposure / covert reporting;
- Increase of the number and type of minor concerns that begin to raise more fundamental questions of governance or competence of the provider to deliver a safe service;
- Highly critical independent service review reports which identify repetitive serious failures;

- Serious concerns raised by the Healthcare Inspectorate Wales, Llais, and Welsh Government Intervention process or professional bodies.

An example of how the escalation process would be applied against the high level dashboard is set out below:

Provider	Date	G Y A1 A2 R Performance Framework Rating Assessment					Escalation Level
		Access	Finance & Activity	Quality & Safety	Patient Experience	Overall Rating	
1	Sep 18					Level 1	**Level 1** – routine monitoring
2	Sep 18					Level 1	
2	Sep 18					Level 2	**Level 2** - Enhanced monitoring
3	Sep 18					Level 3	**Level 3** Enhanced to DPCCMH monitoring
4	Sep 18					Level 4	**Level 4** Escalated to DPCCMH/ intervention Chief Exec informed
5	Sep 18					level 4+	**Level 4** Escalated to DPCCMH/ potential Chief Exec intervention

Table 4.4 Example of escalation level against high level performance overview

Dependent on the level of escalation, the following people would be required to attend the Out of Hours Performance Management Group. A table of Lead Executives for escalated providers will be kept updated. Other Executives will also provide cover where needed.

Level	Attendance at OOH Performance Management Group meetings	OOH Performance Management Group Meeting Frequency
Level 1 - Routine monitoring	▪ Deputy/Assistant Director of Primary Care ▪ Assistant Medical Director ▪ Head of Primary Care - Contracting ▪ Primary Care Manager ▪ Medicines Management representative ▪ Finance Business Partner	Continuous process Quarterly - formal routine monitoring
Level 2 Enhanced monitoring	▪ Deputy/Assistant Director of Primary Care ▪ Assistant Medical Director ▪ Head of Primary Care - Contracting ▪ Primary Care Manager ▪ Medicines Management representative ▪ Finance Business Partner	Bi-monthly – Enhanced Monitoring
Level 3 Escalated to Exec Director	▪ Executive Director of Primary Care, Community and Mental Health ▪ Deputy/Assistant Director of Primary Care ▪ Assistant Medical Director ▪ Head of Primary Care - Contracting ▪ Primary Care Manager ▪ Medicines Management representative ▪ Finance Business Partner ▪ Quality & Safety representative	Quarterly – Enhanced Monitoring including DPCCMH
Level 4 Escalated to Exec Director Intervention Chief Exec informed.	▪ Executive Director of Primary Care, Community and Mental Health ▪ Deputy/Assistant Director of Primary Care ▪ Medical Director Assistant Medical Director ▪ Head of Primary Care - Contracting ▪ Primary Care Manager ▪ Medicines Management representative ▪ Finance Business Partner ▪ Quality & Safety representative	2 weekly /4 weekly Escalated Monitoring CEO/DPCCMH led escalated meetings if there are significant and persistent concerns

Table 4.5 Escalations Levels - Attendance required at Out of Hours Quarterly Performance Management Group

4.7 Chief Executive Level Escalation and Provider Meetings

Where PTHB has persistent and significant concerns that actions are not reducing risks at Level 4 the Chief Executive Officer/DPCCMH will seek a series of focused meetings with relevant executives and the contract holder. A plan focusing on the major risks will be agreed and monitored via an improvement plan.

4.8 De-escalation Process

As the performance improves and risk assessments indicate a reduction in level of intervention required, de-escalation will be discussed and agreed with the DPCCMH/CEO.

PTHB Commissioning Assurance Framework
For Out of Hours Service Provision - Tolerance levels
April 2024 to March 2025

This document supports the Powys Teaching Health Board (PTHB) Commissioning Assurance Framework – Out of Hours Service Provision and details the threshold levels that support and inform the framework.

A	FINANCE (COST AND ACTIVITY)
1.1	Signed contract in place Tolerance level: Compliant – Yes Non-Compliant – No

B	QUALITY AND SAFETY
	Call handling
2.0	**Abandoned Calls** No more than 5% of calls hang up within 60 seconds of the end of the message. **Descriptor** – To measure the percentage of calls where people hang up because their calls are not answered. Tolerance level: Compliant – 95%+ Non-Compliant
2.1	**Answered Calls** 95% of calls are answered within 60 seconds of the end of the message. **Descriptor –** To measure the percentage of calls answered within the timeframe specified. Tolerance level: Compliant – 95%+ Non-Compliant
2.2	**Answered Calls** Percentage of calls where the caller indicates that they wish to contact the call in Welsh. (Welsh speakers are able to opt for Welsh responses at call handling stage of the 111 service).

Descriptor – Identify the percentage of callers that opt for a Welsh speaking call handler

Tolerance level:

Compliant	Yes
Non-Compliant	No

Clinical Triage – Shropdoc and Swansea Bay University Health Board

Timely clinical triage of patients:

- **P1CT** = 1 hour (the 20 minutes response will be retained as an operational measure)
- **P2CT** = 2 hours
- **P3CT** = 4 hours

This is the number of patients contacts that are prioritised by the Out of Hours/111 call handler and then start their definitive clinical assessment within the relevant time bands.

3.0 **Clinical Triage P1**

90% of calls prioritised as P1CT to start their definitive clinical assessment **within 1 Hour** of the end of the first contact

Descriptor – The percentage of P1 callers that begin their clinical assessment within 1 hour timeframe

Tolerance level:

Compliant	90%+
Non-Compliant	

3.1 **Clinical Triage P2**

90% of calls prioritised as P2CT to start their definitive clinical assessment **within 2 Hours** of the end of the first contact

Descriptor – The percentage of P2 callers that begin their clinical assessment

Tolerance level:

Compliant	90%+
Non-compliant	

3.2 **Clinical Triage P3**

90% of calls prioritised as P3CT to start their definitive clinical assessment **within 4 Hours** of the end of the first contact

Descriptor – The percentage of P3 callers that begin their clinical assessment within 4 hours timeframe

Tolerance level:

Compliant	90%+
Non-compliant	

Face to Face

Timely assessment of patients who require face to face appointment at base or home visiting:-

- P1F2F – 1 hour
- P2F2F – 2 hours
- P3F2F – 8 hours

This is measured from the end of the clinical assessment to the start of the patient's face to face appointment, whether that is in a PCC base or home visit.

3.3 **Face to Face – P1F2F - Primary Care Centre/Base**

90% of patients prioritised as P1F2F requiring a **Base appointment** to be seen within 1 hour following completion of their definitive clinical assessment.

Descriptor- The percentage of callers categorised as a P1 who begin their clinical F2F appointment within the 1 hour timeframe

Tolerance level:

Compliant	90%+
Non compliant	

3.4 **Face to Face – P2F2F - Primary Care Centre/Base**

90% of patients prioritised as P2F2F requiring a **Base appointment** to be seen within 2 hour following completion of their definitive clinical assessment.

Descriptor- The percentage of callers categorised as a P2 who begin their clinical F2F appointment within the 2 hour timeframe

Tolerance level:

Compliant	90%+
Non compliant	

3.5 **Face to Face – P3F2F - Primary Care Centre/Base**

90% of patients prioritised as P3F2F requiring a Base Appointment to be seen within 8 hours following completion of their definitive clinical assessment.

Descriptor – The percentage of callers categorised as a P3 who begin their clinical F2F appointment within the **8 hour** timeframe.

Tolerance level:

Compliant	90%+
Non compliant	

3.6 **Face to Face – P1F2F – Home Visit**

90% of patients prioritised as P1F2F requiring a Home Visit to be seen within 1 hour following completion of their definitive clinical assessment.

Descriptor – The percentage of callers categorised as a P2 who begin their clinical F2F appointment within the 1 **hour** timeframe.

Tolerance level:

Compliant	90%+
Non compliant	

3.7 **Face to Face – P2F2F – Home Visit**

90% of patients prioritised as P2F2F requiring a Home Visit to be seen within 2 hours following completion of their definitive clinical assessment.

Descriptor – The percentage of callers categorised as a P2 who begin their clinical F2F appointment within the 2 **hour** timeframe.

Tolerance level:

Compliant	90%+
Non compliant	

3.8 **Face to Face – P3F2F – Home Visit**

90% of patients prioritised as P3F2F requiring a Home Visit to be seen within 8 hours following completion of their definitive clinical assessment.

Descriptor – The percentage of callers categorised as a P2 who begin their clinical F2F appointment within the 8 **hour** timeframe.

Tolerance level:

Compliant	90%+
Non compliant	

3.9 **Base and Home Visit**

99% of patients (Base and Home Visit) (P1F2F, P2F2F and P3F2F) to be seen within 8 hours following completion of their definitive clinical assessment.

Descriptor – No caller should begin their face to face appointment later than 8 hours following the completion of their definitive clinical assessment.

Tolerance level:

Compliant	99%+
Non compliant	

3.10	**Outcome of patient contacts** Of the total number of patient contacts recorded, what was the primary outcome for the patient. No tolerance in place for this. Data received to compare trends and assist with planning future services.
	Triage and Shift Fill
4.0	Percentage of shifts 90% filled. **Descriptor** – Confirmation of shifts filled to the required level. Tolerance level: Compliant: 90%+ Non compliant:
	Clinical Governance
4.1	Clinical governance assurance framework in place. **Descriptor** – Ensuring a system is in place to continuously improve the quality of patient care. Tolerance level: Compliant: Yes Non compliant: No
4.2	Adherence to alert letters - Clinical Governance requirements (confirmation that alert letters are appropriately actioned) **Descriptor** – Confirmation that alert letters are appropriately actioned. Tolerance level: Compliant: Yes Non compliant: No
	Serious Incidents
4.3	Number of incidents per quarter. No tolerance in place for this.
4.4	Undertake review of DATIX and serious incidents including themes. **Descriptor** – To ensure learning from serious incidents is adopted.

Tolerance level:

Compliant	Yes
Non compliant	No

4.5 100% reporting of serious incidents to Welsh Government in agreed timescale

Descriptor – Ensuring adverse incidents are reported.

Tolerance level:

Compliant	Yes
Non compliant	No

4.6 Undertake Clinical Audit using RCGP toolkit, or other appropriate tools, to review 1% of cases on a monthly basis. Audit should include end to end review of the patient's journey through 111 to points of care

Descriptor- To ensure quality care is provided.

Tolerance level:

Compliant	Yes
Non compliant	No

4.7 Clinical audit to be undertaken to learn from serious incidents and demonstrate quality improvement has been adopted, and that reporting is in line with guidance.

Descriptor – Ensuring learning from clinical audit is adopted and that reporting is in line with guidance

Tolerance level:

Compliant	Yes
Non compliant	No

Prescribing

4.8 Prescribing formula in place – i.e. antibiotics = clinical review of cases – in line with clinical governance requirements. Activity data on prescribing practice.

Descriptor – To ensure clinical review is undertaken to affirm or reject that prescribing formula is in place. To understand prescribing practice across each LHB. To explore the patterns between LHB areas to influence changes in working practice

Tolerance:

Compliant	Yes
Non compliant	No

	Risk Management
4.9	Risk Management in place with clear accountability – evidence of an active and appropriate risk log and managerial action – quarterly **Descriptor –** Review of risk register to ensure risks are adequately identified and managed Tolerance level: Compliant – Yes Non compliant – No
	Business Continuity Planning
4.10	An up-to-date Business Continuity Plan is in place and regularly reviewed. **Descriptor –** To provide assurance that key services can continue in the face of disruption for identified local risk. Tolerance level: Compliant – Yes Non compliant – No
	Messaging – 111
4.11	Length of introductory message – no longer than 30 seconds to provide life threatening information, but can contain additional information thereafter – 60 seconds for total message. **Descriptor –** To provide consistency assurance that introductory message complies with guidance Tolerance level: Compliant – Yes Non compliant

C	ACCESS
	Equality
5.0	Ensure the service complies with All Wales standards for equality = audit of language needs – See **DSCN 2017/11 –** reference data source for reporting of language information – see reporting of Welsh callers in PART A of standards and information associated with patients with sensory loss should be recorded – see DSCN 2018/01 = Audit of sensory loss requirements. **Descriptor –** LHB to ensure the response to DSCN 2017/11 and DSCN 2018/01 is captured Tolerance level: Compliant – Yes Non compliant – No

D	PATIENT EXPERIENCE
	Concerns, complaints and compliments
6.0	Concerns and complaints are responded to promptly and within agreed time limits **Descriptor-** To ensure patients concerns are acknowledged, responded to and lessons are learnt Tolerance level: Compliant – Yes Non compliant – No
6.1	Number of complaints, concerns and compliments received by the provider, by Powys Teaching Health Board and by Llais. No tolerance in place for this. Data received is for information only.
	Service User Experience
6.2	Gather and use evidence of service user experience to drive improvement **Descriptor-** To ensure patient's views are gathered and used to improve the service Tolerance level: Compliant – Yes Non compliant – No

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 5.5

Delivery and Performance Committee	**Date: 06 February 2025**
Subject:	**Continuing Health Care – Performance and System Challenges Update**
Approved and presented by:	Executive Director of Primary Care, Community and Mental Health and Assistant Director of Complex Care
Prepared by:	Assistant Director of Complex Care
Other Committees and meetings considered at:	Executive Committee - 22 January 2025

PURPOSE:

To provide an update to Delivery and Performance Committee of the current operational pressures and financial performance in relation to Continuing Health Care/Complex Care.

RECOMMENDATION(S):

The Committee are asked to:

- **REVIEW** and **DISCUSS** the content of this report.
- **NOTE** the actions in place to manage service demand, improve performance and control spending.

Approve/Take Assurance	Discuss	Note
N	Y	Y

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	Y	
2. Provide Early Help and Support	Y	
3. Tackle the Big Four	N	
4. Enable Joined up Care	Y	
5. Develop Workforce Futures	Y	
6. Promote Innovative Environments	Y	
7. Put Digital First	Y	
8. Transforming in Partnership	Y	

EXECUTIVE SUMMARY:

The Committee is aware that Continuing Health Care (CHC) may be applicable following the completion of the Decision Support Tool (DST) process, where a primary health need is identified. This care can be provided in the community or in a care setting such as a nursing home or specialist setting. Committee members understand from previous reports that CHC is a national framework relating to the implementation of a package of ongoing care, funded exclusively by the NHS.

Within the health board, the application, scrutiny, approval, commissioning and contracting is delivered through two teams, the General Nursing Complex Care team (GNCC), covering general medical patients in the community or on the wards of the community hospitals, and the Complex Care and Placements (MHLD) team covering mental health and learning disabilities, across the specialist community teams and mental health wards. The teams comprise experienced registered nurses and administrators. Clinical staff roles vary across the teams intentionally, due to the differing professional needs.

Although there has been progress towards consistency in practice across the whole complex care service over the past year, the diverse nature of the entire workload means that different skill sets and grades are required to deliver the service efficiently. The team structure has been considered by the service leads following the whole service workshop last year and fed into an application to the Investment and Benefit Group in September 2024. A follow up workshop is delayed due to service demand pressures and is planned for in the Spring.

BACKGROUND:

Following a report in August 2024, this report considers both the financial demands and operational pressures of CHC administration. The previous report highlighted improvements in practice and performance in the first two quarters.

The aim of the Complex Care teams is to facilitate the best outcomes for our most vulnerable patients, including end of life. The following factors provide assurance:

- **Sufficiency** – Care package is proportionate to need.
- **Safety** – Identification of risks with the care package
- **Quality** – Plan is able to meet the prescribed patient need.
- **Affordability** – Balance cost with provision and agreed fees.
- **Reliability** - Robust contingency plan is in place and vulnerability of provision is considered.
- **Exceptionality** – On times, an exceptional care package where specific expertise is required.

This is done in the context of prudency relating to public funds. The last report identified that further improvements would need resourcing. The Complex Care teams have been managing sickness absence and practitioner vacancies across both areas with four whole time vacant posts within Q3.

The financial trajectory remains challenging without the capacity to turn off demand in the community, patient needs require expensive care, and this is increasing annually. At month 9, the forecast overspend is **£4.3m** on an annual budget of £31.2m.

Value and Sustainability Board Recommendations

The following 7 recommendations have been made at the All-Wales Value and Sustainability Board.

	Recommendation	**Powys Teaching Health Board: Complex Care View**
1.	An All-Wales IT System	The HB agrees that this is essential to enable analysis of performance and management information. It has been confirmed that the Joint Commissioning Committee (JCC) will take over the national programme however funding is not yet in place.
2.	All Wales support for NHS nurse assessors and reviewers training and competency	This is in place in Powys. Nationally, a team of solicitors will deliver the legal context training and some independent Nurse Assessor training. Financial contributions will be expected from all health boards.
3.	A process to identify opportunities to ensure value through consistent pricing	The HB supports this recommendation however this is not yet in place.
4.	A continuation of the High-Cost Mental Health & Learning Disabilities Placements Reviews	The HB would prefer a partnership approach with plans in place for the national team work with the HB.
5.	Further enhance CHC Health and Social Care Co-operation.	There has been local and national improvement however further leadership co-operation with ADSS Cymru to support local authorities is required.
6.	Strategic Commissioned Care Planning.	The HB agrees however it is important to understand local context and the individual needs of patients.
7.	Improving governance and oversight national and local CHC work	The HB agrees in principle but there needs to be care not to introduce delaying or duplicating administration.

CURRENT POSITION

Team Activity

	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Childrens	0	1	0	0	0	0	1	0	0	0	1	0	0
LD	0	0	2	0	3	0	0	0	0	2	3	0	0
MH	9	19	15	6	20	11	9	2	2	13	14	6	6
General Nursing	83	71	49	71	97	69	67	48	45	70	67	47	40
Total	92	91	66	77	120	80	77	50	47	85	85	53	46

Panel activity varies based on service demand. Mental Health & Learning Disability (MHLD) has a greater number of joint packages with the local authority and this activity does not show in the current methodology of data collection. The MHLD panels are much longer in time allocation due to the complexity and the interface with specialist providers. The general nursing panel has a much higher demand and a faster turnaround due to demand for Fast Track and community packages.

Month	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
CHC	50	32	19	23	15
FNC		26	20	21	17

There is a slight reduction in the number of patients needing care in the community where a package of care has not yet been sourced. Daily calls are undertaken to maximise the opportunity to secure care and enable people to remain at home for as long as possible.

The table below shows the number of active cases per month. Elderly mentally infirm (EMI) has continued to increase significantly over the twelve months. General nursing is reasonably stable across the year with an average of 47 cases per month. Learning Disability has increased by 57%which has significant budgetary impact. Adult MH has increased by 13%.

	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Adult Mental Health	75	75	78	81	78	78	85	83	84	77	76	72	89
Adult Palliative Care	32	30	30	32	29	31	22	26	26	26	36	32	31
Children	5	5	5	5	5	5	6	6	6	6	6	5	5
Community Based/Home Care Support	19	20	18	17	15	15	14	15	14	13	16	13	16
Elderly Mentally Ill Nursing Home	101	104	104	111	107	110	118	118	124	117	135	121	142
General Nursing	44	43	46	44	48	50	51	50	49	48	48	42	44
Learning Disability	37	37	37	37	38	39	44	44	50	44	50	46	58
Respite	0	0	0	0	0	0	0	0	0	0	0	0	0
Grand Total	313	314	318	327	320	328	340	342	353	331	367	331	385

Financial Year to date & Forecast Position

The financial year to date position at month 9 is forecast to be **£4.3m** overspent.

A06 - Asst Dir of Complex Care — £'000

Area	WTE Bud	WTE Act	WTE Var	Avg WTE	Budget to Date	Actual to Date	Variance to Date	Variance Last Month	Variance Change	Annual Budget	Forecast Spend	Forecast Variance	Forecast last month	Forecast change
02.Private Providers	0	0	0	0	756	1,864	1,107	984	123	1,009	2,485	1,476	1,476	0
11. Provider	17	17	(0)	18	727	732	5	5	(0)	969	976	7	8	(1)
41. Continuing Care	0	0	0	0	21,978	23,920	1,941	1,889	53	29,304	32,083	2,778	2,951	(173)
Grand Total	**17**	**17**	**(0)**	**18**	**23,462**	**26,515**	**3,053**	**2,878**	**176**	**31,282**	**35,543**	**4,261**	**4,435**	**(174)**

Funded Nursing Care (FNC) Reconciliation and Revised FNC Rates

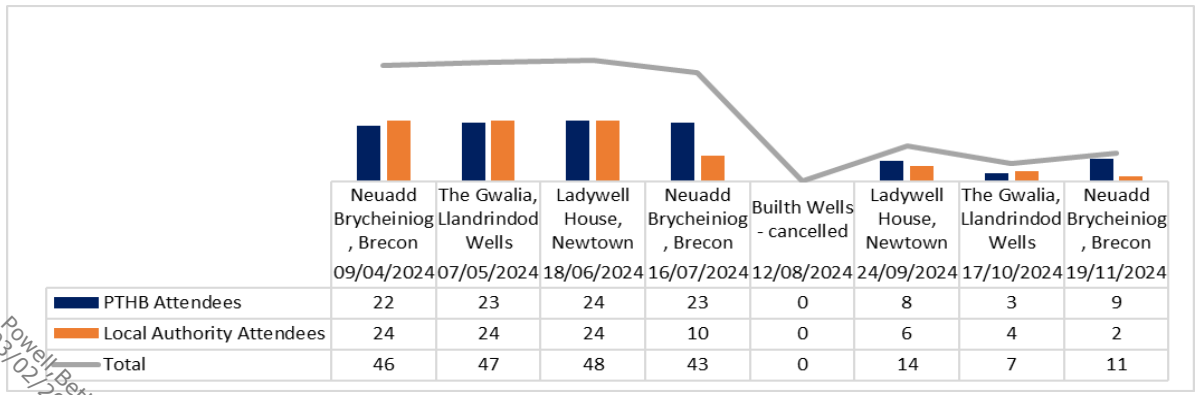
Powys County Council is the lead commissioner for FNC and invoice PTHB. The CHC Administrator checks each spreadsheet against the Care Home data and information held on the National Complex Care Database, for any deaths, discharges, and any anomalies, such as patients placed without the knowledge of the health board. Queries are passed onto the care homes or relevant nurses and a finance summary is submitted. The table below summarises the final 2024/25 Rate for FNC per resident:

	NHS RN Component	Continence Component	NHS Component of FNC	Social Care RN Component	Total FNC
2023/24	£ 192.47	£ 14.48	£ 206.95	£ 8.37	£ 215.32
Uplift	£ 10.59	£ 0.58	£ 11.17	£ 0.46	£ 11.63
2024/25 Final	**£ 203.06**	**£ 15.06**	**£ 218.12**	**£ 8.83**	**£ 226.95**

The additional expenditure of moving from the interim to the final FNC rate is estimated at approximately £60,000.

Staff Training Delivered

Training is one of the seven recommendations from the Value and Sustainability Board and is best completed in partnership. 216 staff across both agencies have been trained since April 2024.



	Neuadd Brycheiniog, Brecon 09/04/2024	The Gwalia, Llandrindod Wells 07/05/2024	Ladywell House, Newtown 18/06/2024	Neuadd Brycheiniog, Brecon 16/07/2024	Builth Wells - cancelled 12/08/2024	Ladywell House, Newtown 24/09/2024	The Gwalia, Llandrindod Wells 17/10/2024	Neuadd Brycheiniog, Brecon 19/11/2024
PTHB Attendees	22	23	24	23	0	8	3	9
Local Authority Attendees	24	24	24	10	0	6	4	2
Total	46	47	48	43	0	14	7	11

Patient Flow

Previous reports have outlined the challenges in maintaining patient flow. The cases without a package of care in the community are monitored and there is a daily programme of action with the aim of obtaining a package of care as soon as a provider can deliver it, this is also a pressure on partner agencies. The co-dependence of services is recognised, reiterating the value of collaborating with partner agencies. The health board can only commission care that is available. Rural areas can be unattractive to care provider organisations due to the challenges of recruitment.

Proportional assessment continues to be used to speed up the placement of hospital patients who are clinically optimised. A robust Nursing Needs Assessment (NNA) may be requested in cases where a DST is declined by the hospital and the Care Transfer Co-ordinator (CTC) will support discharge to a local community hospital within Powys.

REVIEWS

The All-Wales CHC Framework recommends a 3-month review from commencement of the care provision however clinical changes may indicate that an earlier review is advised. Routine, formal reviews are conducted annually, alongside informal reviews and care plan revision. High need and high-cost placements are reviewed as a priority and in the case of enhanced care, predominantly within MHLD, these are tracked and reviewed through the weekly panel process.

Compliance regarding reviews has been maintained but this is a constant balance and keeping this on a positive trajectory impacts on other team functions.

Patient Group	Number overdue February 2024	Number overdue July 2024	Number overdue December 2024
Central Team CHC/FNC	122	21	13
Adult Mental Health/EMI CHC and FNC	16	41	40
Learning Disability CHC	12	13	14
Total	**150**	**75**	**69**

This table reflects the number of overdue reviews at the end of December 2024 and the significant improvement made since February 2024. In January 2025, for the outstanding Learning Disability reviews had reduced to four. They are seen regularly by a range of professionals.

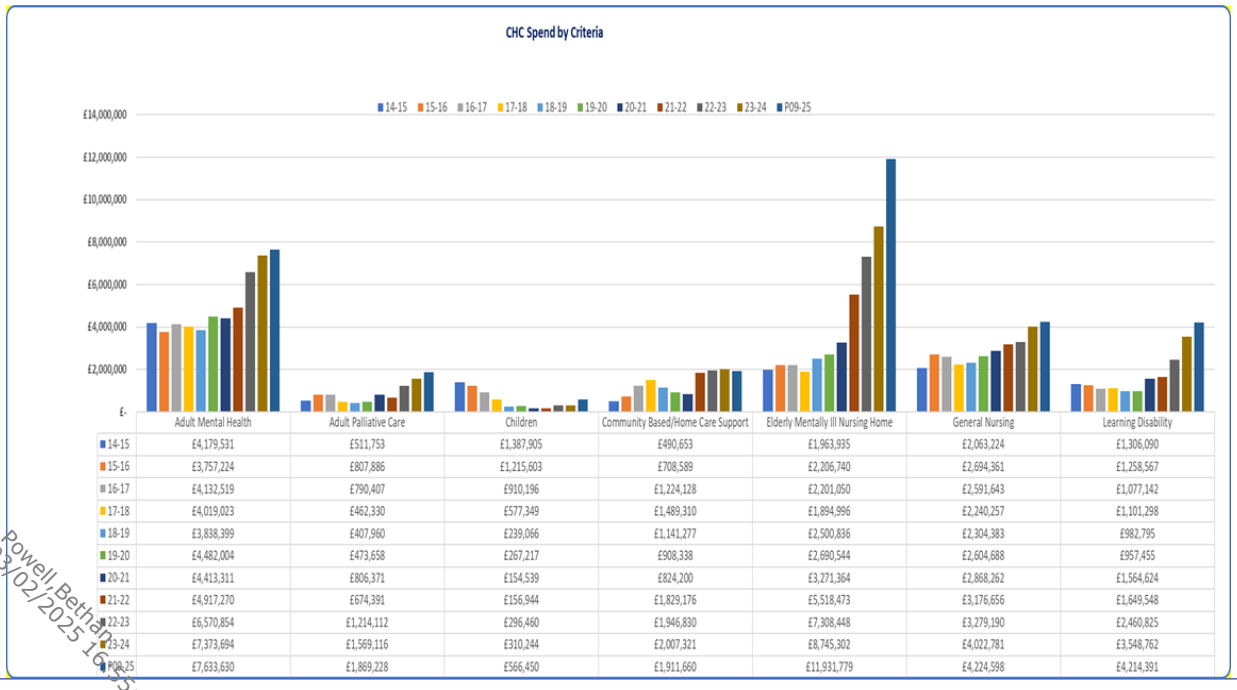
FINANCE

Partnership work with the Finance team continues with the aim of improving the management of fee uplifts with the private sector. The next phase of this work aims to advise care settings of the fee uplifts for the next financial year and to support business planning going into 2025/26.

There have been improvements in relationships with care homes over the last 6 months which enables better sustainability.

M09 Forecast	SOUTH	MID	NORTH	MH	CHILDREN	LD	Total £000
2024/2025							
PACKAGES (current)	17	24	44	205	5	48	**343**
£'000s	£1,186	£2,628	£4,188	£19,597	£566	£4,476	**£32,642**
Days	7,234	9,203	17,014	77,311	1,686	18,563	**131,011**
Avg cost per day	£164	£286	£246	£253	£336	£241	**£249**
2023/2024							
PACKAGES (current)	25	29	37	194	5	37	**327**
£'000s	£1,955	£2,123	£3,475	£16,201	£310	£3,549	**£27,613**
Days	11,215	9,818	13,413	67,457	1,830	14,727	**118,460**
Avg cost per day	£174	£216	£259	£240	£170	£241	**£233**
Forecast Change							
PACKAGES (current)	(8)	(5)	7	11	0	11	**16**
£'000s	(£769)	£504	£713	£3,397	£256	£927	**£5,029**
Days	(3,981)	(615)	3,601	9,854	(144)	3,836	**12,551**
Avg cost per day	**(£10)**	**£69**	**(£13)**	**£13**	**£166**	**£0**	**£16**
Impact Breakdown							
Increase in Days (@23/24 £)	(£694)	(£133)	£933	£2,367	(£24)	£924	£3,372
Increase in Daily Fee	(£75)	£638	(£220)	£1,030	£281	£3	£1,656
	(£769)	**£504**	**£713**	**£3,397**	**£256**	**£927**	**£5,029**

Month 9 Forecast - The table below higlights the growth in costs over the last 11 years. This is a consistent trend across Wales however the EMI and Adult Mental Health position in particular has had a significantly disproportionate impact for Powys.



	Adult Mental Health	Adult Palliative Care	Children	Community Based/Home Care Support	Elderly Mentally Ill Nursing Home	General Nursing	Learning Disability
14-15	£4,179,531	£511,753	£1,387,905	£490,653	£1,963,935	£2,063,224	£1,306,090
15-16	£3,757,224	£807,886	£1,215,603	£708,589	£2,206,740	£2,694,361	£1,258,567
16-17	£4,132,519	£790,407	£910,196	£1,224,128	£2,201,050	£2,591,643	£1,077,142
17-18	£4,019,023	£462,330	£577,349	£1,489,310	£1,894,996	£2,240,257	£1,101,298
18-19	£3,838,399	£407,960	£239,066	£1,141,277	£2,500,836	£2,304,383	£982,795
19-20	£4,482,004	£473,658	£267,217	£908,338	£2,690,544	£2,604,688	£957,455
20-21	£4,413,311	£806,371	£154,539	£824,200	£3,271,364	£2,868,262	£1,564,624
21-22	£4,917,270	£674,391	£156,944	£1,829,176	£5,518,473	£3,176,656	£1,649,548
22-23	£6,570,854	£1,214,112	£296,460	£1,946,830	£7,308,448	£3,279,190	£2,460,825
23-24	£7,373,694	£1,569,116	£310,244	£2,007,321	£8,745,302	£4,022,781	£3,548,762
P09-25	£7,633,630	£1,869,228	£566,450	£1,911,660	£11,931,779	£4,224,598	£4,214,391

The position has deteriorated significantly in 2024/25 due to a reduction in in-patient beds early in the year and the increased demand in out of County placements. There are currently 10 patients with high-cost treatment and 1 to 1 costs.

The CHC Budget is based on the 2023-24 forecast expenditure plus an inflationary uplift that has been added for 2024-25. The Month 9 position is overspent by £1,941K and forecast to overspend by £2.778m. The overall patient numbers have increased from 328 at the end of March to 343 at the end of December.

The service's £430k savings target was focussed on discharge to recover and assess (D2RA) and has been achieved for 2024/25.

Actions to impact the level of demand and the cost of services
Public Health are in the process of assessing whether there are demographic drivers underpinning the increase in demand. Early indications are not showing a significant age impact and work is due to be completed by the end of Q4.

Learning Disabilities partnership working with PCC has increased to twice monthly meetings to proactively review high-cost placements. This approach promotes the best patient outcomes and shares the cost. It diverts conflict and shares understanding of responsibilities and the needs of individuals. This means that cost burdens are not shunted between organisations, but timely decision-making and practice focus, remains on effectively and efficiently meeting need together. This positive, partnership working ensures that potential debt accrual does not reoccur and significantly builds professional trust.

The MHLD team is undertaking early exploratory work in the north of Powys to develop a new enhanced care model. A placement where 24 hour 1:1 care is required could cost £5900 per week, compared to an Enhanced Care rate of £2,800. Although 1:1 arrangements are monitored closely and reduced as soon as possible, there remains a number of people who require this individual support for long periods. An Enhanced Care environment negates the need for 1:1 provision and is a less restrictive option. This development will be updated in the next report.

GOVERNANCE

Service governance is managed through a panel process. The Complex Care Operational Management Group (CCOMG) reports to the Quality, Safety and Experience Group for Complex Care (QSEG). It had been the intention to reset the governance and reporting interface between nursing and the operational services in the Autumn, however due to the absence of key roles, this has not yet taken place and will be resolved in Q4. The Executive Director for Nursing retains the CHC professional oversight.

ISSUES AND RISKS

Duty of Quality for complex care must ensure that the quality of health services and outcomes is improved through commissioning arrangements. Each individual has a unique set of needs and prudency in the public sector is essential to make sure that

there is a reduction in waste Balancing the cost of package with quality of service is complicated, skilled work and the workforce model is under review.

Data management continues to create risks and there is currently no nationally agreed and funded solution to mitigate the current gaps.

Six appeals are ongoing challenging decisions around eligibility for CHC. The team has undertaken some positive work, revising the standard operating procedure for CHC Appeals, creating a step-by-step guide and tracker. A similar process review is underway for Retrospective Claims and this will be completed in Q4. There is one case in dispute with the local authority at stage one of the process.

The whole system capacity and service demand continues to create cost pressures. Previous reports have highlighted the risks around the health board's capability to commission care in the community. There are currently 15 community cases where there is no care available to meet assessed need although the number of patients awaiting care has reduced significantly over Q3 from 35.

Complex Care Retrospective Claims
At the end of Q3, there were 12 active cases, of which 4 had only recently been allocated. All cases had breached which could result in a financial impact if eligibility for CHC is approved. PTHB remains the only health board in Wales without a dedicated team to manage retrospective claims for CHC.

A member of staff oversees the process and manages the cases which has had an impact on general duties. This ensures that the claims are continually monitored as required by Welsh Government (WG). A spreadsheet is maintained and reported to Welsh Government on a bi-monthly basis. There is a reciprocal obligation for health boards to support each other with peer reviews and to sit on Independent Review Panels (IRP).

There has been an increase to 12 current retrospective claims from the 9 reported previously and additional administrative support is required to step forward the plan to resolve cases more quickly.

CONCLUSION AND NEXT STEPS

The priorities for Complex Care will be identified in the IMTP for 2025/26 and will include:

- **Data management** – The development of a clear dashboard / dataset to ensure performance of the team. This is linked to one of the national recommendations through the V & S Board.
- **Workforce plans** – Team structure options recognising that the current organisation of the teams is based on the recognition of the different functions of each specialised area of work. Although there are some consistencies, the differences require dedicated specialist provision. To date, there has been no new

investment in the Complex Care services although the creation of the Assistant Director role was funded through the Learning Disability budget.

- **Review collaborative opportunities** with the local authority to ensure a timely, appropriate, and prudent commissioning system – ensuring a getting It Right First Time (GIRFT) approach which has a clear timeframe for delivery. Plans to meet with the local authority are in place.
- **Focus on the spend** – Work with the national team to develop a clear program of work and the benchmarking with Hywel Dda University Health Board is underway. Next meeting is February 2025.

Welsh Government implemented a new code of practice in September 2024. The National Framework for the Commissioning of Care and Support in Wales: Code of practice states that; *Commissioning encompasses both the planning, procurement and evaluation or review of services. It is about fulfilling the statutory responsibilities of the local authority, and the NHS in shaping services to both prevent or delay, where possible, a need for care and support and to respond to the care and support needs of people both now and in the future.* As part of the Social Services and Well-being (Wales) Act 2014.

The Complex Care teams work within this code of practice, requiring investment of time; capacity to understand the changes and to work with the complexities that new commissioning partnership work will bring. There are other new responsibilities coming for the NHS, such as the use of Direct Payments.

NEXT STEPS:

- Presentation of the work with Public Health around demographic impacts for Powys CHC.
- Completion of the Benchmarking work with Hywel Dda University Health Board
- Completion of the NHS Wales supported work around CHC spending trends
- Workshop planning for the Spring
- Fast Track challenges from PCC has resulted in a number of helpful discussions at a senior level. An independent professional review has been agreed and a meeting to agree the Terms of Reference between both organisations is set for February 2025. There have been no cases where care has been delayed.

References

- National framework for commissioning care and support (WHC/2024/0234) Directions to local health boards and NHS trusts to comply with the national framework - National framework for commissioning care and support (WHC/2024/0234) [HTML] | GOV.WALES

IMPACT ASSESSMENT – NOT REQUIRED FOR THIS REPORT

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 5.6

Delivery and Performance Committee	**Date: 6 February 2025**
Subject:	**Food Safety Compliance and Assurance Follow Up Report**
Approved and presented by:	Pete Hopgood, Executive Director of Finance, Capital and Support Services
Prepared by:	Professional Lead for Catering and Environmental Cleanliness – Development, Improvement & Technical Compliance
Other Committees and meetings considered at:	Innovative Environments Group - 19 December 2024 Executive Committee – 22 January 2025

PURPOSE:

The purpose of this report is to provide a six-monthly assurance update on the current compliance levels of food safety in relation to statutory regulations, guidelines, and best practices.

The report will detail the setup of the catering services to meet statutory regulations, the organisation of these arrangements, the management, monitoring, and control processes in place, and the overall performance of the services in achieving a high standard of compliance.

RECOMMENDATION(S):

The Delivery and Performance Committee are asked to:

- **RECEIVE** this report and take **ASSURANCE** that appropriate quality control measures are in place.

Approve/Take Assurance	Discuss	Note
Y	Y	N

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	Y	
2. Provide Early Help and Support	N	
3. Tackle the Big Four	N	
4. Enable Joined up Care	Y	
5. Develop Workforce Futures	N	
6. Promote Innovative Environments	N	
7. Put Digital First	Y	

8. Transforming in Partnership	N	

EXECUTIVE SUMMARY:

This report outlines the significant progress made in food safety management across PTHB hospitals, building on the previous report's findings. Key achievements include the successful implementation of a refined Food Safety Management System (FSMS), maintaining high Food Hygiene Ratings (Level 5) across all sites, and the introduction of a new catering assurance system that has effectively reduced serious non-compliance issues. Staff training efforts have also been enhanced, with improved completion rates and the rollout of bespoke Toolbox Talks on safe catering practices. Furthermore, supplier management continues to ensure that only compliant products are accepted, maintaining high food safety standards.

However, challenges remain, particularly with achieving 100% compliance in audit completion rates and further refining allergen control systems. Two isolated incidents related to allergen management have highlighted the need for enhanced staff training and clearer communication. To address these issues, recommendations have been made to strengthen training, implement 'fail-safe' controls, and revise procedures for allergen control. The introduction of the Catering Management Information System (CMIS) is underway and will improve allergen tracking and food production management.

Looking ahead, the next six months will focus on further refining food safety processes, achieving full audit compliance, and evaluating the effectiveness of training initiatives. The continued development of the CMIS and a focus on staffing and skills development will ensure that PTHB maintains the highest standards of food safety for the well-being of patients, staff and visitors.

DETAILED BACKGROUND AND ASSESSMENT:

Introduction

In the previous report, we highlighted that food safety in hospitals across Wales is governed by a combination of UK-wide regulations, specific Welsh laws, and NHS Wales standards. These frameworks are essential to ensure that food provided within PTHB hospitals, meets the necessary safety and hygiene standards, safeguarding the health of patients, staff, and visitors.

We also discussed the complexity of managing catering services in this environment, emphasising the importance of understanding key regulations, guidelines, and best practices, again as outlined in Appendix 1. These regulations stress the need for effective interpretation and the creation of robust internal management systems to ensure ongoing compliance 24/7, year-round.

Operationally, catering services are managed by two Band 7 Support Services Managers, each responsible for different sites, with support from Band 5 Facilities Coordinators, Band 3 Facilities Supervisors, and Band 2 catering staff. The Professional Lead for Catering and Environmental Cleanliness – Development,

Improvement & Technical Compliance plays a critical role in ensuring regulatory requirements are met, developing policies and procedures, and managing the risk of a single point of failure, given their role as the sole subject matter expert in this field.

The report also emphasised that the provision of catering services carries inherent risks, particularly for vulnerable patients, and that meticulous management and supervision are essential. This includes ensuring proper staffing, maintaining equipment and facilities, and strictly following operational procedures. Routine checks and controls are necessary to maintain continuous compliance, ensuring that food safety standards are upheld, and food products remain safe to consume.

This follow-up report will continue to assess how the catering safety system is functioning, update on its performance, and address any developments or improvements made since the last review.

Key Achievements and Progress

The operational management structure continues to be a cornerstone of PTHB's success. Band 7 Support Services Managers, Band 5 Facilities Coordinators, and the Lead for Catering and Environmental Cleanliness remains instrumental in driving improvements. The continued focus on the recruitment of good quality catering staff within the team has helped strengthen capacity, enabling more effective management and supervision of day-to-day operations. Recruiting such staff is particularly difficult due to the limited number of qualified individuals residing in the county, especially when considering the broader opportunities available in other public sector and private organisations in Powys.

The continued intense focus on Food Safety Management compliance has made a valuable contribution to embedding the Food Safety Management System (FSMS) more consistently across all hospital sites. Ongoing refinements of food safety procedures and documentation, including Hazard Analysis Critical Control Point (HACCP) assessments and audit records, has resulted in a more streamlined system. A step up of the frequency of internal auditing consistently show high levels of compliance and greater awareness of staff’s responsibilities for with food safety requirements.

The newly developed catering assurance systems have been fully implemented since February 2024. Monthly reporting within the Support Services Assurance system continues to be rigorously followed, ensuring that any failings are identified early and addressed promptly. The reports from the Catering Assurance Group show a clear reduction in the number of serious non-compliance issues and reassuringly an increase in the number less serious compliance issues. This demonstrates that the audit tools are effective, and that full transparency is applied during audits i.e. if we see it, we report it and do something about it.

The rolling annual Food Hygiene Rating inspections conducted by the Environmental Health show a continuation of PTHB hospitals to excel in

maintaining the highest Food Hygiene Ratings (Level 5 – Very Good) across all sites. Since the previous report, additional unannounced inspections have been conducted, and all sites inspected have continued to pass with top ratings. Since the impressive turnaround at Bronllys Hospital following the improvement plan after their October 2023 EHO inspection the team are confident that their standards will pass with flying colours when their next due unannounced visit is undertaken, and which is expected at any time.

Supplier management and compliance has seen continued success, with all food procurement activities monitored in accordance with our HACCP system. Deliveries failing to meet the requirement checks detailed in our HACCP are visible through the newly developed escalation mechanism where the detail of an occurrence reports directly to our NWSSP partners who then hold suppliers to account for failures and ensuring that only compliant products are accepted. This additional mechanism reflects the ongoing vigilance and commitment we have to food safety.

Staff training remains a priority, with significant progress made in the implementation of food safety training programs. Over the past six months, there has been an improvement in the completion rate of training, and the process for tracking and reporting training completion has been enhanced. The development of bespoke Toolbox Talks on safe catering practices has been completed and rolled out during the last reporting period.

Challenges and Areas for Further Improvement

While the overall progress is positive, there remain a few areas that will require continued attention.

Audit Completion Rates: Although there has been a marked improvement in the number of internal management catering compliance audits completed, further work is required to ensure 100% compliance with the timely completion scheduled audits. Continued monitoring and addressing of any barriers to completing these audits will be a focus in the coming months.

Allergen Control Systems: The preparation for the introduction of the Catering Management Information System (CMIS) to enhance allergen control and food production management is progressing. Once implemented, the CMIS will allow for more accurate tracking of food delivery, production, and allergen control, further improving the management of food safety risks related to allergens.

During this reporting period, two isolated incidents were identified where the management of allergens and intolerances did not meet the requirements outlined in the approved procedure. Investigations into both incidents revealed common root causes and provided several recommendations summarised as follows:

- Enhance training and awareness for catering staff.

- Increase allergen risk awareness among ward staff during mealtime services.
- Implement cross-checking and 'fail-safe' controls across all staff groups.
- Promote improved communication across all staff groups.
- Revise PTHB/FTP 009 Standard Operating Procedure for Food Allergen Control to include the additional revised control measures.

Operational Staffing Capacity: While excellent progress has been made toward achieving near full operational capacity, it is essential to maintain a strong focus on ensuring complete staffing and further developing their knowledge and experience through additional training opportunities and exposure to new skills.

The Health Board's recently adopted recruitment freeze could have serious implications for patient safety and nutritional wellbeing if applied to catering staff. This group, along with cleaning and portering staff, should be exempt from the recruitment freeze due to their direct role in delivering patient care.

Conclusion
PTHB has made substantial progress in improving food safety compliance, building on the systems and measures outlined in the previous report with ongoing enhancements to training, assurance reporting and system integration and food safety across all hospital sites remaining a top priority. Moving forward, continued efforts will focus on refining processes, addressing any remaining challenges, and maintaining the highest standards of food hygiene and safety to ensure the well-being of all patients, staff, and visitors.

NEXT STEPS:

The next six months will focus on the following key areas:

Further Refinement of Catering Assurance Systems:
Continued improvements to the assurance reporting and monitoring systems will be made to ensure all areas of food safety are consistently maintained and any issues swiftly addressed.

Review the Rollout of Toolbox Talks and other Enhanced Training:
Evaluate the effectiveness of the bespoke Toolbox Talks on safe catering practices, specifically its completion rates and the visible improvements to practices that can be directly attributed to this specific training. Identify any additional training that would be helpful to support improved skills amongst the catering teams.

Achieve 100% Compliance with Catering Audits: Targeting full compliance with catering audits, the next six months will involve focusing on training staff to complete audits on time and in full, ensuring that all areas of food safety are thoroughly checked and documented.

Introduction of Catering Management Information System (CMIS):
To continue with pace the development of data requirements for the introduction of the CMIS. Its implementation will significantly enhance PTHB's ability to manage food production, delivery, and allergen control.

Regulatory Compliance and Other Guidelines and Best Practices

Food Safety Act 1990 - This is the primary legislation for food safety in the UK, including Wales. It places a duty on food businesses (including hospitals) to ensure that food is safe to eat, of the nature, substance, and quality expected by consumers, and correctly labelled.

General Food Law Regulation (EC) 178/2002 - Establishes the general principles of food safety and food law. Ensures food traceability, sets out the responsibilities of food business operators and mandates the withdrawal and recall of unsafe food.

Food Hygiene (Wales) Regulations 2006 - Specific regulations for Wales that implement EU food hygiene regulations. Sets out hygiene requirements for all stages of food production, processing, distribution, and placing on the market.

Regulation (EC) 852/2004 on the Hygiene of Foodstuffs - Sets the hygiene requirements that food businesses must follow. Covers general hygiene requirements for premises, equipment, food handling, and the implementation of procedures based on HACCP principles.

Regulation (EC) 853/2004 Laying Down Specific Hygiene Rules for Food of Animal Origin - Includes detailed requirements for the handling, processing, and storage of meat, dairy, fishery products, and eggs.

Regulation (EC) 2073/2005 on Microbiological Criteria for Foodstuffs - Establishes microbiological criteria for food safety. Specifies microbiological standards for pathogens in food products and process hygiene criteria.

The Food Information Regulations 2014 - Implements the EU Food Information to Consumers Regulation. Mandates labelling requirements, including allergens, nutritional information, and origin labelling.

Official Controls (Animals, Feed, and Food) (Wales) Regulations 2006 - Provides for the execution and enforcement of food safety and hygiene regulations. Establishes the framework for official controls, including inspections, sampling, and enforcement actions.

The Food Hygiene Rating (Wales) Act 2013 - Introduces a mandatory food hygiene rating scheme for food businesses in Wales, including hospitals. Requires

food businesses to display their hygiene rating, which is determined by local authority inspections.

The Public Health (Wales) Act 2017 - Addresses various public health issues, including food hygiene. Provides powers to address public health risks, which can include foodborne illnesses and hygiene standards in public institutions like hospitals.

Other Guidelines and Best Practices

NHS Wales Catering Services Nutrition and Catering Standards - Provides guidelines and standards for hospital catering services. Ensures that hospital food meets nutritional and safety standards, catering to the specific needs of patients.

Food Standards Agency (FSA) Guidance - The FSA provides extensive guidance on food safety, including for healthcare settings. Covers topics like food hygiene practices, allergen management, and safe food preparation and storage.

HACCP (Hazard Analysis and Critical Control Points) - A systematic preventive approach to food safety. Hospitals must implement and maintain HACCP plans to identify, evaluate, and control food safety hazards.

IMPACT ASSESSMENT

This section must be completed for all strategic organisational decisions including approval of health board policies.

QUALITY:

	No impact	Negative	Positive	Both	
Safe			×		This paper provides a six-monthly assurance update on the current compliance levels of food safety in relation to statutory regulations, guidelines, and best practices.
Timely	×				
Effective	×		×		
Efficient			×		
Equitable	×				
Person Centred	×				
Workforce	×				
Leadership	×				
Culture	×				
Information			×		
Learn, Improve, Research	×				
Whole Systems Approach	×				

EQUALITY:

	No impact	Negative	Positive	Both
Age	×			
Disability	×			
Gender reassignment	×			
Marriage / civil partnership	×			
Pregnancy / maternity	×			
Race	×			
Religion or Belief	×			
Gender	×			
Sexual Orientation	×			
Welsh Language	×			
Socio-economic status	×			
Social exclusion	×			
Carers	×			

RISK ASSESSMENT:

	Level of risk identified			
	Very Low (0-3)	Low (4-8)	Moderate (9-12)	High (15-25)
Clinical		×		
Financial		×		
Corporate	×			
Operational		×		
Reputational	×			

Agenda item: 5.7

Delivery and Performance Committee	Date: 06 February 2025
Subject:	**Digital First Assurance Report**
Approved and presented by:	Claire Madsen Executive Director of Allied Health Professions, Health Science and Digital
Prepared by:	Chief Digital Data Officer
Other Committees and meetings considered at:	Executive Committee – 22 January 2025

PURPOSE:

To provide a Digital First update and assurance relating to the delivery of the Digital, Data and Technology Services within Powys Teaching Health Board (PTHB).

RECOMMENDATION(S):

The Delivery and Performance Committee are asked to:

- **Take ASSURANCE** that work is progressing and delivering against the Digital Strategic Framework, to embed a clinically led digitally enabled service in support of Digital First as a Strategic enabler for transformation, improvement, quality, safety and efficiency.
- **NOTE** the key achievements.
- **NOTE** the challenges.

Approve/Take Assurance	Discuss	Note
x		x

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	N	
2. Provide Early Help and Support	Y	
3. Tackle the Big Four	N	
4. Enable Joined up Care	Y	
5. Develop Workforce Futures	Y	
6. Promote Innovative Environments	Y	
7. Put Digital First	Y	
8. Transforming in Partnership	Y	

EXECUTIVE SUMMARY:

This report will provide an overview of progress, challenges and areas needed for improvement in the following key areas:

- Clinical Informatics Progress Update
  - Clinical Priority Matrix
- Digital Technical ICT Support Services
  - Client Services Performance (Helpdesk and Field Support Engineers)
  - Cyber Security
  - Infrastructure and Networking
  - Procurement
- Data and Business Intelligence
  - Robotic Process Automation (RPA)
  - Cloud Data Store/Local Data Resource
- Local Programme updates
  - Virtual Consultations
  - Integrated Medium Term Planning 2025/26
  - Whole System Review
  - Print Management
  - Digital Dictation
  - Cross Border
- Nationally Driven Programme updates
  - Digital Maternity Programme
  - Electronic Prescribing Medicines Administration (EPMA)
  - Welsh Community Care Information System (WCCIS) replacement
  - RISP
  - National Data Resource (NDR)

PROGRESS UPDATE

Clinical Informatics Progress Update

We have established a clinically led, digitally enabled group (Digital Improvement, Prioritisation, and Reporting Group) to convene clinicians and heads of service. This group will meet for the first time in February (21st) and will systematically review performance dashboards with the objective of enhancing clinical and patient outcomes through the strategic utilisation of digital solutions.

The key objectives of this initiative are:

- Conducting comprehensive analyses of performance dashboards to identify opportunities for the enhancement of clinical practices and patient care through digital solutions.
- Monitoring the utilisation of digital tools, such as digital dictation, via license usage dashboards to ensure accountability in the investment and effective use of digital technologies.
- Investigating persistent inefficiencies, such as high volumes of printing despite the implementation of print management solutions and facilitating collaborative discussions to address these challenges and this data will inform the Business Efficiencies programme, and the Digital Transformation Board Agenda

By fostering these discussions and analyses, we aim to promote efficiency, accountability, and continuous improvement in our clinical services, thereby ultimately leading to improved patient and staff satisfaction and outcomes.

Additionally, and going forward this group will collaboratively help to prioritise digital projects and ensure the group's focus will be on proposed initiatives that align with strategic priorities, considering patient safety, and deliver measurable benefits for patients, staff, and the organisation as a whole.

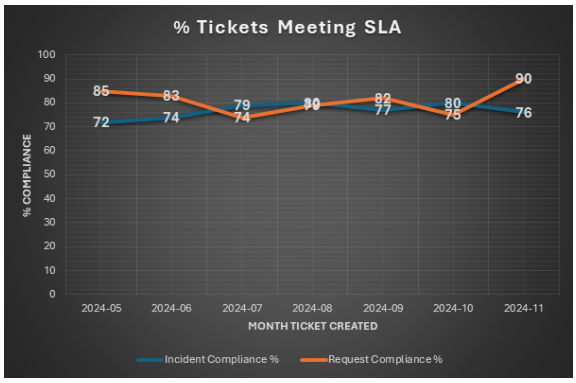
By adopting a structured and transparent approach to digital prioritisation, the group will support the effective allocation of resources, promote innovation, and drive meaningful and sustainable improvements across the organisation. This will be a primary focus for 2025/26 with the first meetings being held in February and March 2025

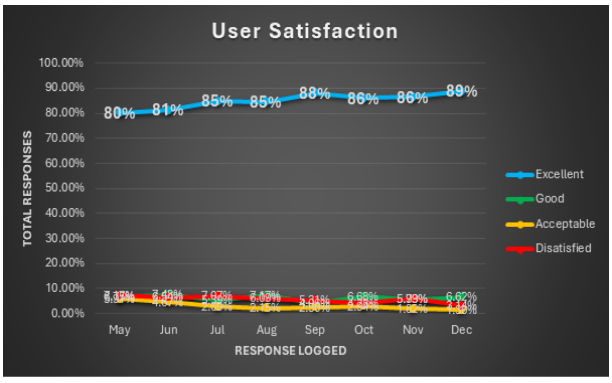
Digital Technical ICT Support Services

Client Services Performance (IT Service Desk and Field Support Engineers)

Following the client services team transfer to Health Board in May 2024, SLA performance has improved from the previous year. The trend for Incident & Request compliance has remained steady between May and December 2024.

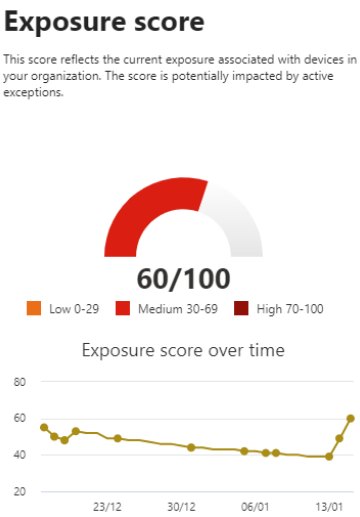
Feedback from staff over the same period has demonstrated a steady increase in customer satisfaction. Current efforts are to continually review the support experience across client services teams by standardising processes, improving documentation and aiming to speed up activities where possible that impact on the customer experience. Staff training and development is also a priority for the client services team. See Appendix A for further performance KPIs.





Cyber Security

Maintaining a high security posture on behalf of the Health Board is an essential but increasingly complex and demanding task. We maintain routine remediation of software vulnerabilities across our client and server estate and provide assurance of new digital initiatives consumes current operational capacity.



External Audit reports continue to demonstrate improvement in our cyber security posture. The Health Board is positively maintaining pace and, in some scenarios, ahead of other NHS Wales organisation in this area. Efforts are being made to address remaining best practices and external audit findings, but progress is limited due to capacity. A demand and capacity exercise will be required to report this in more detail.

Infrastructure and Network

In recent months, the infrastructure teams have been focused in three main areas.

- Digital Telephony Upgrade System Rollout – The Health Board now has an entirely digital telephone service, future proof and able to adapt to business needs. This project has completed slightly later than planned due to networking complexity, and there is a final phase to complete to configure the Welsh Language on main patient lines, which will complete by mid-February. This project has meant that many unused lines have ceased, with all lines ceasing by the end of the financial year. Financial forecasts developed at project initiation forecast dual running of systems for six months. Due to some implementation delays, a large proportion of dual running costs remained in place until nine months. A small proportion of lines are still in place and are in the process of being removed. The extended period of dual running costs have meant that there is some unplanned pressure on the budget. Actual financial cost pressure can be calculated during March 25. Deployment of some telephones to unwanted locations will be recovered and re-deployed as the service needs to grow. These unwanted handsets do not change the financials for this financial year.
- Network Infrastructure Improvement – A programme of wireless and wired network infrastructure improvements continues across the Health Board. This work increases our capability, reliability and throughput.
- Secure Hosting arrangements – 95% of our services have been migrated to a secure network segment. A significant portion of this work required a major re-engineering of our primary and secondary datacentre in Bronllys & Spa Road respectively. Work has also been completed to address our physical security to protect the devices hosting our sensitive data. This work was technically challenging, but necessary piece of work that needed completing, having the

strengthened capability within the Infrastructure team, following the appointment of new resources has enabled this work to be undertaken as a priority, the result is less outages and quicker resolution to fault finding issues should they occur. This work is expected to complete this financial year.

There does however remain a backlog of necessary infrastructure improvements to replace portions of our network on several sites. Inefficiencies in our network design and topology are being implemented alongside this work to ensure that the Health Boards infrastructure can respond to evolving digital needs. This has been a priority focus for Welsh Government Capital Bids and where much of the IT resource has been allocated, given the Infrastructure and networking are the foundation of digital access and availability. This work requires a significant amount of downtime on each site to achieve the full replacement of infrastructure. This is usually completed on the weekend and is limited to the availability of a small team.

Service Management, Procurement & Asset Management

Process improvements in our client services department have been improved by automation and process flows implemented in our IT Service Management (ITSM) Tool (HALO). Continuous improvement in flows requires that our supporting ITSM is also continuously developed. These improvements and automations allow us to operate more efficiently with the resources we have. It is fair to say that despite significant progress, the teams are in their infancy of developing automation and flows, this will we hope to improve the time. These automations aim to speed up and improve efficiency for asset procurement, audit, cataloguing, allocation and maintenance.

Improvement is needed in the following Digital Technology areas:

- Standardise and ensure consistency in support provided by our service desk and field service engineers. Staff training and development sessions are scheduled for the first quarter of 2025. This is expected to be an ongoing activity to support service delivery and customer experience.
    - Conduct training sessions with service desk analysts and field service engineers to standardise support processes and procedures.
    - On completion of the training sessions success will be measured through customer satisfaction reports and performance metrics within Halo.
    - The aim would be for a reduction in ticket resolution time and an increase in customer satisfaction. All training guides will be uploaded to the Knowledgebase within Halo for ease of accessibility. Follow-up sessions would be provided for any staff members requiring additional support.
    - Consistent support will lead to higher customer satisfaction and will deliver a better service.
    - Complete initial training sessions within three months and offer refresher sessions after 6 months to maintain and continually improve support.
- Improve contract management for digital services including assets and applications, licenses etc. This will aim to provide robust lead times to contracts

that expire, and also monitor Supplier Cyber compliance, and help to negotiate new contracts ensuring the best prices are agreed.
    - The allocation of a dedicated resource to manage digital contracts, procurement and renewal to reduce late payments and gaps in maintenance.
    - Measurable impact in late payments and unplanned contract expiry.

- Improve knowledge transfer between teams and individuals to distribute workload away from those with high technical or local organisational knowledge.
- Introduce a structured workflow of projects / initiatives into the delivery teams to ensure prioritisation and effort is targeted, structured and monitored. We recognise there are still some silo' d gaps in our internal way of how teams operate, this will be reviewed via the demand and capacity exercises we plan to conduct throughout February and March 2025.

Challenges:

- Digital Inflation continues to put pressure on digital budgets, we are expecting an increase in the cost of our contracts and SLAS with Digital Health and Care Wales (DHCW). The industry is suggesting this may be between 10% and 15%, depending on the specific technology and pricing metric used, with some reports showing increases in hardware like laptops and servers reaching up to 20% in price hikes; software prices are also seeing significant inflation, with increases around 15-20%.
- There are expectations that digital initiatives can be integrated within the current resource capacity. However, this is challenging due to the need to deliver on the Digital Strategic Framework, maintain Business as Usual activity, and support both local and national transformation initiatives and innovations. We continue to recruit at risk.

Data and Business Intelligence

<u>Cloud Data Store/Local Data Resource:</u>
The Local Data Resource programme of work is progressing at a good pace. The Health Board's Cloud Data Store is now fully established and acts as the robust technological foundation on which all data will be stored & used within the Health Board.

Being cloud based means that PTHB's Data Platform is the first in NHS Wales to have migrated to a cloud platform in this way. It provides increased resilience and performance but more importantly is more cost effective and future proofs the Health Board's data capabilities, Powys Teaching Health Board is therefore fully cloud first in our Data Platform and activities.

This platform is fully compliant with relevant General Data Protection Regulations (GDPR) & Information Governance (IG) rules as well as being aligned to the National Data Resource (NDR) platform hosted in Digital Health and Care Wales

(DHCW). The platform is also 'A.I Ready' meaning that the Health Board currently utilises A.I to streamline productivity and enable more efficient access to data, by reducing the time to query data sets through specific programming language so this means the A.I elements are used to help the Digital teams accelerate their acquisition of data into the platform.

The next phase of this work is to extend the use of the A.I element of the platform and using it as a tool for end users to 'talk' to their data to help bridge the gap between the owning services and their data. We are also looking to onboard additional services' data stores into the platform to turn it into a true 'one source of the truth' for the Health Board.

There is a shift in the way the Health Board works with data that is required to fully use this newly created platform. There is a need to conduct an Intelligence Mapping review which will add meaning and insights to the data being collected and held by the Health Board – meaning that we can shift from a reactive to a proactive environment to enhance patient care. This is being looked at in conjunction with Digital, Transformation & Other services within the Health Board.

Challenges and Learning
While we have promoted data ownership within services, we did not fully consider the implications of 'ownership.' Services are now in some areas viewing their data as potentially incomplete or of poor quality, leading to reluctance in sharing it, as it may not accurately represent their position. This highlights the need for us to improve data quality, understand how data is shared and used, and ensure confidence in the accuracy of data, given its importance for strategic decision-making.

The data quality is now categorised as:

- **Bronze** = Raw Data in our Data Store. Not to be accessed as standard practice to any service area but the Data Team as the data is often not useable and needs 'cleaning, verifying and '.
- **Silver** = Cleansed data as its moved from the Bronze Layer which has been signed off by both Digital Data expertise and the owning service. This data often contains Management Data and Patient Level information and is subject to relevant security & IG processes and is the first layer of data readily available to the wider health board on a permission and need basis (IG Legal Basis etc).
- **Gold** = Non Patient Level data freely available to the Health Board without any additional need to request access.

Further Planned activities include:

- Implement a cloud-based data platform to centralise all Health Board data Achieve a 20% reduction in data retrieval time by utilising AI elements in the data platform by Q4 2024/25.
- Increase the percentage of cleansed data (Silver level) available to the wider health board by 20% by Q4 2025.

- Identify dedicated resource requirements to conduct an Intelligence Mapping review to enhance data quality and shift from reactive to proactive data usage.
- Provide training sessions for staff on the new cloud-based data platform to ensure smooth adoption and usage.
- Align the data initiatives with the Digital Strategic Framework to support the overall goal of becoming a data-driven organisation.
- Ensure that the data platform is fully compliant with GDPR and Information Governance rules to maintain data security and privacy.
- Complete the onboarding of additional services' data stores into the cloud platform by the end of Q4 2025/26.
- Conduct quarterly reviews of data quality and usage to ensure continuous improvement and alignment with strategic goals.

Local Programme Updates

Virtual Consultations

In alignment with 'A Healthier Wales' and as part of the Welsh Government's emergency response, video consultations were implemented across all Welsh Health Boards in March 2020. The NHS Wales Video Consultation Programme and Service was managed and coordinated nationally by Technology Enabled Care (TEC) Cymru; a Welsh Government funding programme hosted by Aneurin Bevan University Health Board.

During this period, Health Boards stood up local delivery teams to implement video consultation services based upon their organisational priorities. They provided the NHS Wales Video Consultation Programme with essential information, expertise, insights, and resources. In March 2025, the national contract ends and after careful consideration, a decision was made and agreed by executives to sign a 12-month contract with Attend Anywhere to allow the continuation of virtual consultations with the same supplier, known for their reliability and useability. However, we will continue to review the market offering for Digital Video consultations, and also look to where we can consolidate other digital solutions such as Digital Dictation into one product. The market is evolving at a fast pace, but we do also need to consider the business change impact of changing solutions and what that has on our front line staff.

Video consultations significantly improve access to healthcare services. Many patients, particularly those in rural or underserved areas, face challenges in accessing healthcare due to geographical barriers and travel constraints. A video consultation platform allows these patients to receive care without the need to travel. Additionally, patients with mobility impairments or chronic conditions can find it difficult to visit healthcare facilities, making video consultations a convenient and necessary alternative that ensures they receive timely care.

To encourage and influence an increase in usage of virtual consultations, digital inclusion in existing patient facing surveys will be used to demonstrate an

expectation from patients wishing to use virtual consultations and target departments where there the data supports this.

Positive feedback from existing departments using the service will also be used to identify efficiencies and improved patient experience and clearly articulate the benefits to both the service and to patients.

Challenges
Despite significant efforts to onboard and train staff and improve connectivity, some service areas are still not utilising video consultations. This lack of adoption can negatively impact patients by limiting their access to convenient and timely healthcare services, especially for those in rural or underserved areas. Additionally, it can hinder overall service efficiency by increasing the burden on in-person consultations and visits and potentially leading to longer wait times and reduced capacity to handle patient needs effectively.

Plan to increase adoption
Understanding the success or failure of platform preferences in healthcare services requires a multi-layered analysis of various factors, including the nature of the service, trust and comfort levels, accessibility, technological proficiency, and security concerns. To address these obstacles, the following actions will be required.

- A positive campaign will be launched to boost usage, particularly in planned care with the implementation of patient initiative follow up (PIFU), and it may also support the future development of virtual wards.
- Engagement with the leads in the lower usage areas to see what support can be given to increase usage.
- Learning from Powys Living Well Service (PLWS) who are 94% digital
- Dialogue between the user, project team and the provider
- A programme of work continues to strengthen the wi-fi across Powys
- Widening the access to WCP for visiting consultants so they can access results online SLA's have been reviewed with the consultants to ensure it is agreed that Virtual Consultations will be offered as a blended approach where applicable.

Integrated Medium Term Planning 2025/26
The 2025/26 Integrated Medium Term Planning has been completed. Given there has been significant improvement in our Infrastructure, Networking, Data platform, and local initiatives such as Print management and telephony upgrade, as the foundations are in a much better status, our focus will be in measurable improvements to digital solution adoption, this will ensure we are working in collaboration with our clinical peers and front line staff, dedicating our time to support and learn through working together.

Whole System Review
The whole system review, designed to look at all our clinical systems in use in Powys THB, and those that we know will be replaced such as (WCCIS) and some

of the All Wales Systems such as WPAS that we are informed will not be further developed, has unfortunately slowed in its pace of delivery due to the national pace directing our timescales. This is being closely monitored through our corporate risk CR0012.

Fact finding and information gathering for the review has already taken place, and while it is still the aim to review all the systems in the Health Board, the focus has had to be re-aligned to progressing the WCCIS replacement as a priority (covered in the National Updates below).

The challenges related to this piece of work are primarily focussed on the availability of local resource due to the number of programmes of work that are happening within 2025/26, and also the need for robust pathway mapping, and process mapping across the patient journey. This work has started and is ongoing.

Print Management

The printer replacement is complete and operating as business as usual. Good progress has been made in removing desktop printers and localised printers to deliver the information governance benefits outlined in the business case. Less than 50 non-standard printers now exist across the estate and teams are actively removing them. A by 'service and by user' dashboard is in development to publish printer usage across the estate for service managers to review and ideally reduce unnecessary printing.

One to one conversations have taken place with high usage users to ascertain what is being printed and if it can be replaced by a digital method i.e., secure portal email exchange, Share Point site to share documents.

Some complexities of shared buildings between the Health Board and other organisations remain an issue for a minority of buildings. Work is ongoing to resolve these issues.

A project closure report will be produced by Q4 2024/25, and the Print Management solution will be fully embedded in Business As Usual support (BAU). Many cost-saving benefits have been identified, ranging from reducing the expense of consumables to decreasing the volume of prints by avoiding unnecessary printing. It is essential to have health board-wide support to ensure a reduction in printing to provide future savings.

Digital Dictation

Over the past few months, a discovery piece of work has taken place for a replacement digital dictation solution across the health board which will support introducing a unified AI Speech Recognition solution to improve efficiencies through a procurement exercise.

The current dictation landscape in PTHB is not standardised, posing risks that can cause delays in patient care. Furthermore, there are cases of teams urgently needing dictation tooling but there is not a dictation strategy or specific vendor for this service, resulting in six separate digital solutions in use in the Health Board as services are able to procure directly without this being managed through robust digital application governance processes.

The multitude of solutions presents a challenge for the Digital Services team, one of many that the team are actively trying to manage. Within these solutions there are multiple instances, versions, and team dependencies created by different ways of working. This complicates the support that can be provided and elongates the time to resolve issues faced by the teams. Ultimately, this delays a letter being produced and care provided to patients.

Many of these solutions are also near or at the end of their lifecycle. Suppliers will not support issues, the original application can no longer be obtained, and for some teams the lack of transferability of the application is blocking the refresh of equipment. These make services more vulnerable to failure which will delay the team in producing letters.

Fixing an issue with dictation often requires an on-site visit by the Field Engineer often the issue is devices or application issue that cannot be supported remotely. This is a more costly way to provide support and creates a delay to resolution for the user. This delay then impacts the patient receiving the letter, or a clinician for the patient being informed of their care. These delays mean that patient's care is not joined up at the earliest point possible, and that the inefficiencies impact the patient journey.

For clinicians and administrators, introducing a unified solution would:

- Reduce the administration time and cost of typing.
- Reduce the occurrence of repetitive strain injuries and fatigue that is associated with excessive typing.
- Release time for more engagement with patients.
- Provide flexible working options, including teams working together to support with the backlog of dictation.
- Adopting a single solution

This approach will not only streamline operations but also centralise and optimise resource allocation, offering the best return on investment. By adopting this AI-driven dictation solution, we can elevate our service delivery, ensuring better patient outcomes and operational excellence. Again, the license and usage of digital dictation will be closely monitored to ensure value and efficiency returns on the investment made.

Cross Border

With over 50% of Powys Teaching Health Board's Secondary Care provided by neighbouring Welsh Health Boards or by Trusts across the border in England, such as Shrewsbury and Telford Hospital Trust (SaTH), Wye Valley NHS Trust, and Robert Jones Agnus Hunt, it became essential for our local and visiting consultants to have digitised access to patient records in Powys to prevent unnecessary delays in patient care.

In 2021, there was a joint business justification case made between Powys Teaching Health Board (PTHB) and Digital Health and Care Wales (DHCW) to request Welsh Government (WG) investment to fund a project to allow NHS Wales patients who are treated in NHS England to have their administrative and clinical data and information managed and accessible through NHS Wales digital systems.

The investment provided by WG was £1,205,188 (Revenue Funding) over the 2-year lifetime of the Project (spanning three financial years). This funding was depleted on 30th June 2024.

Following two gateway reviews; the latest conducted in February 2024 and previously in May 2023, a review took place where risks, issues and challenges associated with the project was undertaken by the wider project team. It was highlighted that actions had not progressed that were integral to gaining approval and sign off on all relevant documentation associated with its internal assurance process for each project workstream which raised several concerns.

To address the issues and challenges, it was recommended to the Project Board in March 2024 that several workstream deliverables be de-scoped, focusing instead on those that were viable and achievable. DHCW agreed that the assurance process for each workstream needed to be expedited before solutions development and Go Live. The Project Board approved this approach.

The project scope was therefore revised to include four workstream deliverables instead of the original six, excluding Shrewsbury & Telford Hospital (SaTH) and St Michael’s Clinic NHS England trusts from the scope.

1. Clinic/Discharge Letters with Wye Valley Trust (WVT)
2. Pathology Results with Wye Valley Trust
3. Clinic/Discharge Letters with Docman Connect GP Sites into Primary Care
4. Access to the GP Record via the Welsh Clinical Portal (WCP)

Progress has been made over the past month with Wye Valley Trust, supporting the integration of Pathology results and Clinic Letters into the Welsh Clinical Portal by May 2025. Successful testing with each NHS England Trust has been completed to enable access to the GP Record via the Welsh Clinical Portal. Additionally, efforts are underway to allow GP practices to receive discharge summaries from Robert Jones and Agnes Hunt (RJAH).

There is still low confidence this project will be delivered by March 2025 as planned, due to resource constraints at DHCW, and the progress is reported to the Executive Committee on a monthly basis due to slippage in milestones and is now an active escalation agenda item. We are however now hopeful the work will be completed by May 2025.

National Programme Updates

Digital Maternity Programme
Following an halted national procurement for a digital maternity system the Health Board is now preparing a business case to support local adoption and implementation. WG are supporting and funding these local implementations for financial year 2025/2026 only. An existing business case is being updated to support this work internally for presentation to IBG this financial year. The deadline however is very tight, the framework to direct award requires completion of procurement documentation by mid-February and WG require the Business Case submissions for the funding offered no later than March 31st, 2025, this is to ensure the supplier can complete the implementation and go Live by March 2026

Electronic Prescribing Medicines Administration (EPMA)
A key component of Welsh Government's A Healthier Wales policy is the investment and use of digital technology to improve patient care.

The implementation of electronic prescribing and medicines administration (ePMA) systems in every ward in every NHS hospital across Wales is a priority for the Welsh Government. The intention is that paper medicines charts/prescriptions will be replaced as prescribing and medicines administration across all Welsh hospitals moves to a digital system.

The Powys THB ePMA project is focused on procuring and implementing an ePMA solution for community hospital in-patient services in phase 1 and outpatient and community services in phase 2.

The project has faced challenges through 2024/25 with national delays in funding and approval of the internal business case. The funding letter for 2025/26 is yet to be received which means resource was extended at risk for a further 12 months.
After a long tender exercise, a supplier was appointed in September 2024 and discussions continue to review and sign off schedules that feed into the overall contract. Once signed the team will start configuring the system and commence early adoption in readiness for implementation.

Welsh Community Care Information System (WCCIS Replacement) the Connected Care Programme
The National replacement of the Health and Social Care system 'Care Director' also known as the WCCIS programme is now in Phase 2 and renamed to the

'Connecting Care' Programme. It is currently hosted by DHCW and was scoped for an implementation of a Social Care System, A mental Health System and a Community Care System, with a view that the systems do not need to be the same but there must be data sharing and interoperability between them.

Social Care is no longer in scope of the national programme and Social Care have completed procurement for their replacement system. Health Boards are engaged with their Senior Responsible Owner (SRO) boards to ensure Health Boards are consulted and informed.

Mental Health & Community. Currently the pace of delivery of the national programme is not meeting the expectations of the Health Boards and so all Health Boards are currently looking at a collaborative procurement approach similar to that of Social Care. Betsi Cadwaladr University Health Board (BCU UB) are leading the procurement of a Mental Health Solution with Cym Taf Morgannwg Health Board (CTM HB) as a fast follower due to the special measures the Health Boards are currently facing, and other Health Boards are invited to join this exercise. This means that Health Boards can collaborate in the specification and supplier scoring, and will then be named on the awarding contract, to enable a fast procurement should the Health Board choose to award to the same supplier, however there is no obligation to do this, or timescale in which do to this, it is at each Health Boards situation and decision. PTHB has given the no obligation agreed to be named on the BCU HB procurement exercise and workstream and is actively collaborating with them and other Health Boards on a Mental Health Solution.

The Community Care solution, for Powys is still aligned to the National Programme, and is an active board member, however the pace continues to be slower than expected.

Challenges relating to the Connecting Care programme are around timelines. The delay in the National programme hosted by DHCW may mean there is a shift to a Health Board centred approach, similar to that with the Digital Maternity Programme, and if so, it will happen quite quickly. This will then mean local resource within the Health board redirected to deliver the WCCIS replacement.

<u>Radiology Information System Programme (RISP)</u>
The digital workstream of the RISP Project is supporting a planned go live in April 2025. The new supplier, Philips, is offering a managed service with devolved health board systems.

Local infrastructure has been deployed in the health boards datacentres and is being implemented by Philips and their subcontractors.

Engagement with subcontractors to implement supporting services and procurement of dependant infrastructure is in process. There are some risks to

procurement and delivery of this dependant infrastructure, but there are mitigation measures in place to ensure there are no technical blockers.

National Data Resource

The National Data Resource programme (hosted by DHCW) continues to be delayed across multiple workstreams. There are a number of underlying issues focused on the Information Governance and Technology of the platform that continue to prevent PTHB (and other HBs) from using the solution. PTHB representatives within the various NDR groups continue to engage with the programme to aid DHCW where possible.

Next steps are for the national programme to engage with IG leads throughout NHS Wales to progress and resolve the underlying IG issues (specific to data ownership, control, access and usage). This will then make it clear as to what the platform is legally allowed to do or not do when it comes to the data it holds. There is also a recognised gap in the programme with the continual delay of a Data Catalogue which is a fundamental component of the platform to give federated organisations the assurance they require about the data being held in the platform. This continues to be raised & escalated in various NDR forums however delivery timelines of this element remain unclear, and milestones continue to slip (the data catalogue for example has slipped by almost 2 years).

Challenges relating to this piece of work are primarily focussed on priorities and timelines for the National programme. There are a large number of partners involved with the programme who may have conflicting priorities that can lead to a lack of clear timelines. There are however a number of other programmes of work that are reliant on the NDR programme so there is risk if it continues not to deliver.

NEXT STEPS:

Continue with the planned programme of work and ensure the Integrated Medium and Long Term plans align to the delivery of the Digital Strategic Framework 2023-2027.

Collaborate with Finance, Planning and Transformation teams to develop robust work plans for specific targeted transformational activities.

Conduct a Demand and Capacity exercise across the whole digital services directorate and review the current structure for efficiency, capacity and capability to support future requirements.

Continue with planning and reporting against the following:

1. **Enhance Clinical Practices and Patient Care:** Conduct comprehensive analyses of performance dashboards to identify opportunities for the enhancement of clinical practices and patient care through digital solutions. This will be measured by the number of identified opportunities and their subsequent implementation.

2. **Monitor Digital Tool Utilisation:** Monitor the utilisation of digital tools, such as digital dictation, via license usage dashboards to ensure accountability in the investment and effective use of digital technologies. Success will be measured by the percentage increase in digital tool usage and reduction in inefficiencies
3. **Address Inefficiencies:** Investigate persistent inefficiencies, such as high volumes of printing despite the implementation of print management solutions and facilitate collaborative discussions to address these challenges. The goal is to reduce printing volumes by a specific percentage within a set timeframe.
4. **Prioritise Digital Projects:** Collaboratively help to prioritise digital projects and ensure the focus will be on proposed initiatives that align with strategic priorities, considering patient safety, and deliver measurable benefits for patients, staff, and the organisation as a whole. This will be measured by the number of prioritised projects and their successful completion.
5. **Improve Customer Satisfaction:** Continuously review the support experience across client services teams by standardising processes, improving documentation, and speeding up activities that impact the customer experience. Success will be measured by an increase in customer satisfaction scores.
6. **Enhance Cyber Security:** Maintain a high security posture by routinely remediating software vulnerabilities and addressing external audit findings. Progress will be measured by the number of vulnerabilities remediated and improvements in external audit reports.
7. **Upgrade Network Infrastructure:** Complete the Welsh Language configuration of the digital telephony upgrade system rollout, and continue with network infrastructure improvements to increase capability, reliability, and throughput. Success will be measured by the completion of these projects within the set deadlines and the resulting improvements in network performance.
8. **Improve Data Quality:** Conduct an Intelligence Mapping review to add meaning and insights to the data being collected and held by the Health Board. The goal is to shift from a reactive to a proactive environment to enhance patient care, measured by the completion of the review and the implementation of its recommendations**.**
9. **National Programme Updates**: Progress with the Digital Maternity Programme, Electronic Prescribing Medicines Administration (EPMA), and the Welsh Community Care Information System (WCCIS) replacement. This will be measured by the number of national programmes in and their successful phased completion**.**

Report the Digital First Updates to the Delivery and Performance Committee as scheduled to provide assurance on progress, challenges, and areas for improvement.

IMPACT ASSESSMENT – NOT REQUIRED FOR THIS REPORT

Appendix A – KPI Report December 2024.

Contents

Report Introduction

This report offers a thorough overview of service levels and compliance in managing digital services. It covers various aspects, including service level targets, overall compliance in handling requests and incidents, and compliance breakdowns by team. Additionally, the document examines the top incident-generating services and user experience monitoring.

The primary goal is to monitor and enhance the efficiency and effectiveness of digital service management. This report is intended for managers who need to understand how the demand on and performance of the Digital Services team could impact their own teams.

Executive Summary

The findings from this report indicate that December experienced a lower volume of incidents and service requests, which is expected due to the reduced number of staff working during this period. There is minimal discussion on SLA compliance this month, as this is the first report where we are offsetting the reporting by a month. Consequently, the commentary remains the same as in November 2024.

Digital Tickets

Tickets are used to structure, prioritise, and track work completed by the Digital Services. These tickets are generated through several methods:

- Email – An email is received from a staff member or supplier that generates a new ticket (this does not include emails that are matched to existing tickets)
- Portal – A ticket is created by using the forms on https://powysthb.haloitsm.com/portal/home
- Auto – A ticket is created automatically by Halo as part of an automated ticket process i.e. tickets in the New User Process, kit installation requests after equipment has arrived
- Manual/Phone – These tickets are created by a member of the team, usually by the Service Desk.

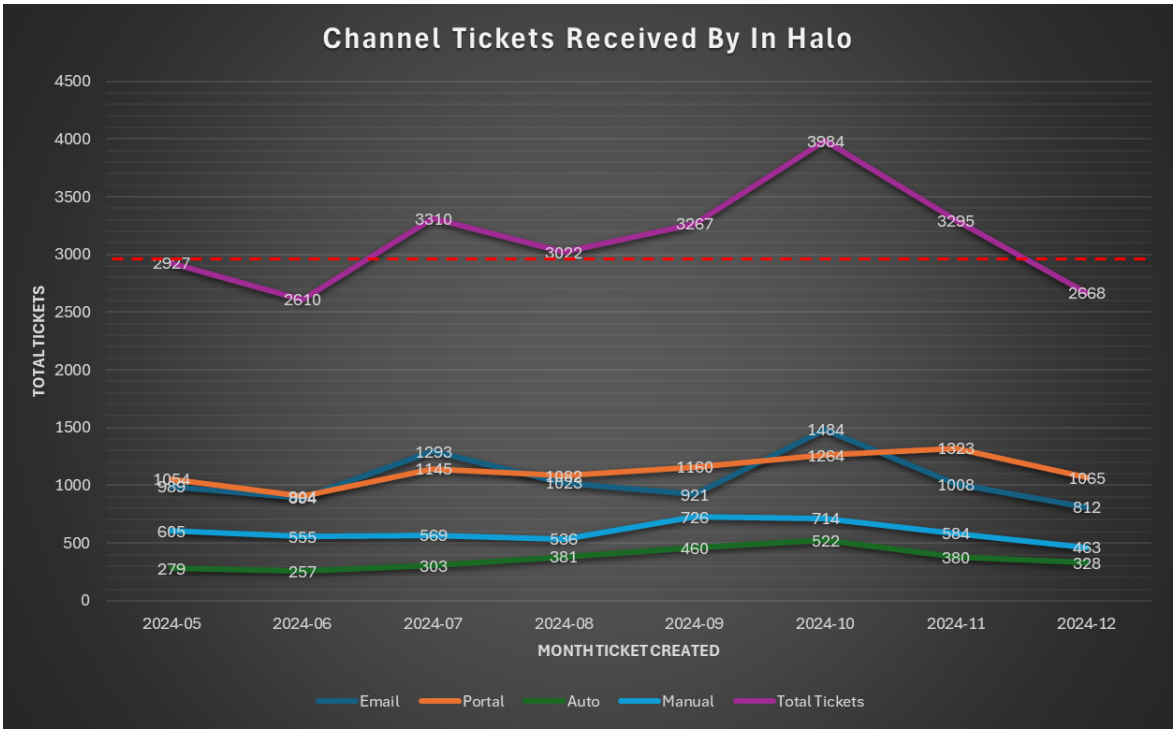


Figure 1 - Ticket generation by method the ticket was received.

The graph above depicts the number of tickets and the method by which they were received.
As expected, the total number of tickets in December has dropped. This drop has had minimal impact on the average which remains around 3000 ticket per month.

Implications

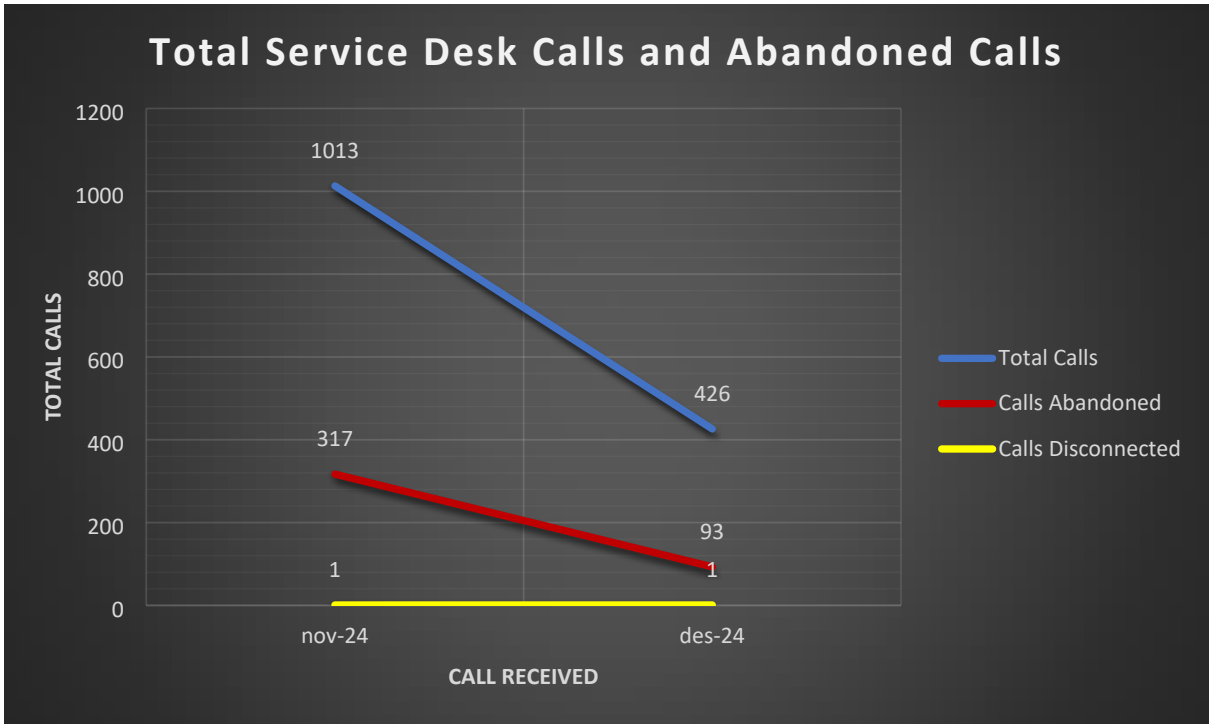
Stabilisation in the data will enable predictions of demand that can inform:

- Staff resource requirements
- Creation of baselines to better measure the impacts of service changes aimed at improving user experience

Continued adoption of the portal can be reducing the total commitment in time spent logging tickets. This can free up the phone lines for calls with greater urgency whilst also saving clinicians time waiting on the phone.

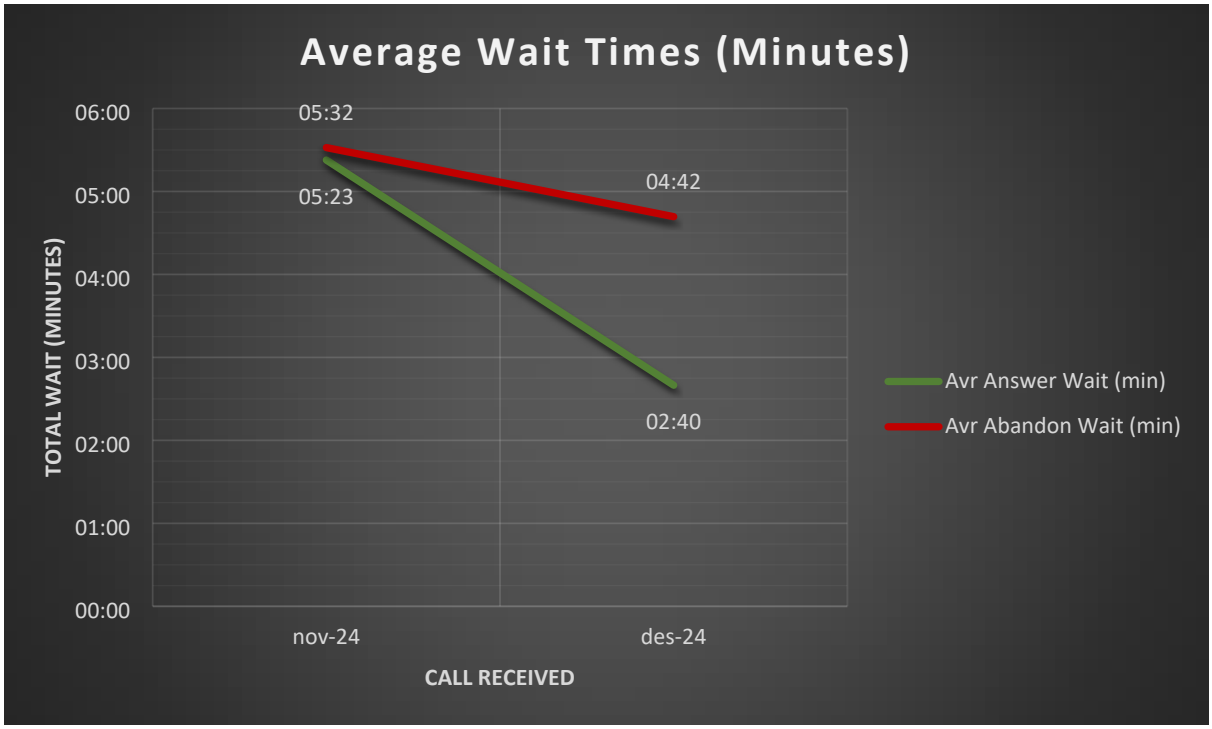
Service Desk Calls

The below graph shows the call volumes. This is a new dataset and due to limitations in data kept in Microsoft 365, we can only report from Novemver 2024. This will build with time.



December saw a reduction in calls, as would be expected for the time of year. The proportion of abandoned calls did not decrease in line with the trend for total calls. However, this is attributed to leave taken by the Service Desk during this period.

Only 1 call was disconnected due to overflow. This occurs when the call queue either is at capacity or where a call waits for the maximum amount of time, which is set at 45 minutes. This call was received on the 18th December at 12.14pm. According to the dashboard, this caller waited 45 minutes on the phone before being disconnected. Further investigation revealed that the Service Desk had only one call handler due to lunch breaks and another team member transporting assets. The call handler was engaged in two calls for a total of 29 minutes. It appears they then spent time documenting those calls instead of moving on to the next waiting call. The Client Services Lead will address this incident with the team, ensuring that during periods of limited availability, prioritising answering calls takes precedence over documentation.



Compared to November 2024, the average wait time for answered calls and abandoned calls decreased. This will be in line with the reduced volume of calls. The wait times before answer met the 2-3 minute targets set by Operational Level Agreements (OLAs) and Service Level Agreements (SLAs) with Health and Care Research Wales (HCRW). However, there were still calls that were abandoned and waited for an average of 4 minutes. This aveage is likely impacted by the disconnected call waiting for 45 minutes, therefore explain the inconsistency with the prior trend of similar times.

Implications

Staff may experience increased frustration with the service if they do not receive a timely response to their issues. Some staff members still prefer to call the Service Desk, and an extended wait time can be a negative experience for them. However, this situation could encourage greater adoption of the portal.

Incident & Request Trending

Service Requests range from requests for new equipment and software licences, to information and 'How Do I' requests.
Incidents indicate a failure, fault or problem with our digital services that impacts staff productivity or their ability to deliver care.

Both these ticket types represent a productivity cost to the health board and efforts are required to ensure the total number is reduced as well as the total time it takes to resolve them.

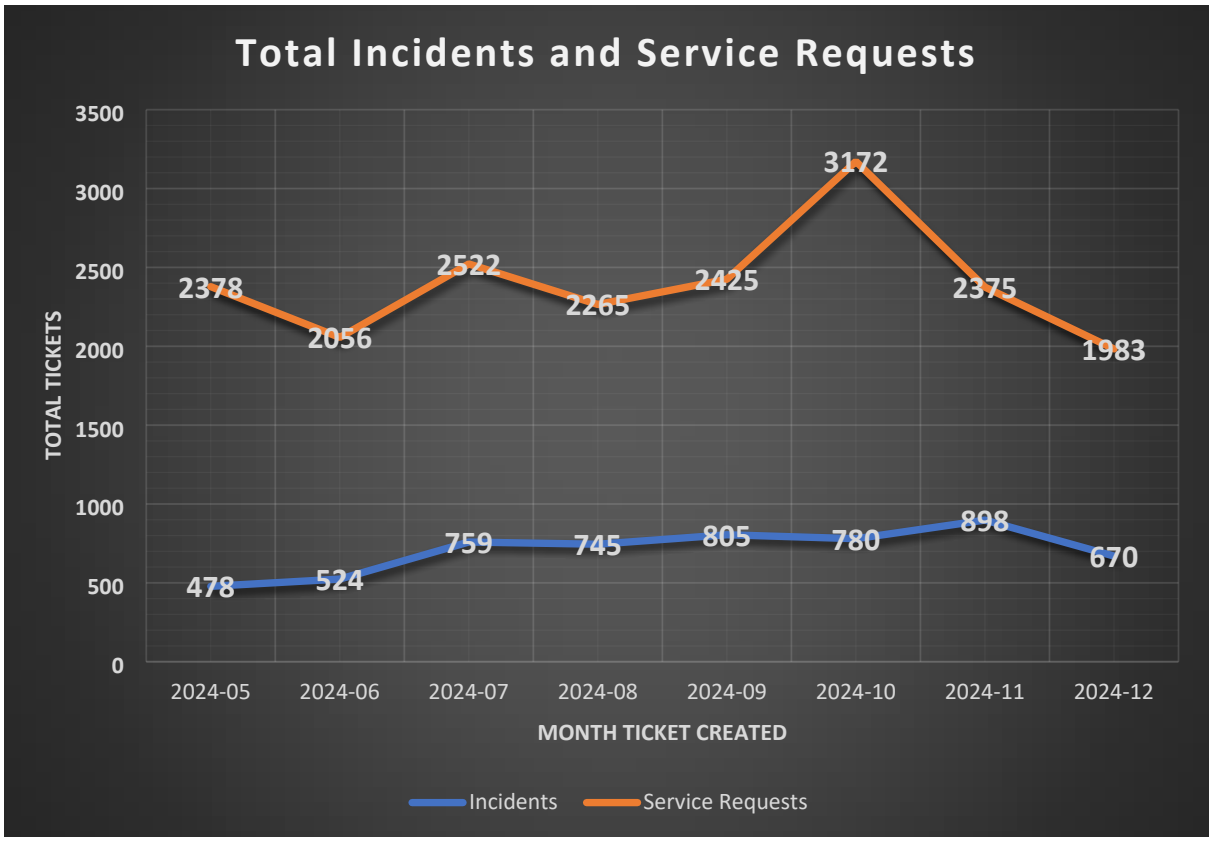


Figure 2 - Total incidents and requests by month

Service Requests Trends

Service requests are much higher than incidents in the Health Board. As expected, the number of requests decreased.

Incidents Trends

The total number of incidents also decreased, as expected. Whilst the total decrease in incidents was higher than service requests (25% vs 16%), if you compare the decreased in incidents to the baseline then the decrease (14%) is comparable to service requests. This provides evidence that November saw a peak in incidents compared to the baseline and adds weight to the assumption we have reached a plateau in ticket generation.

Our aim is to reduce the frequency of incidents over time. We'll look to achieve this by: -

- Maintaining sustained investment in the removal of legacy infrastructure and client devices from our estate.
- Continue the expansion of automatic problem detection and remediation. Fixing problems before users are even aware of them.
- Sustained efforts to remove single points of failure in our infrastructure and digital services.

The data continues to indicate that current efforts have successfully stemmed the increase in the number of incidents. Additionally, allocating resources to these efforts is expected to further reduce the number of incidents.

Service Level Targets

Digital Services set the following service response targets.

Requests

Priority	Resolution Target
Expedited Request	3 Days
Standard Request	5 Days
Low Priority Request	10 Days

Incidents

Criticality	Response Target	Resolution Target
Emergency Healthcare Impact across Health Board	1 Hour	2 Hours
Critical Healthcare Impact at a single site	1 Hour	4 Hours
Major Departmental Impact	2 Hour	8 Hours
Normal User Impact	4 Hour	12 Hours
Low Limited Impact / Annoyance	8 Hour	16 Hours

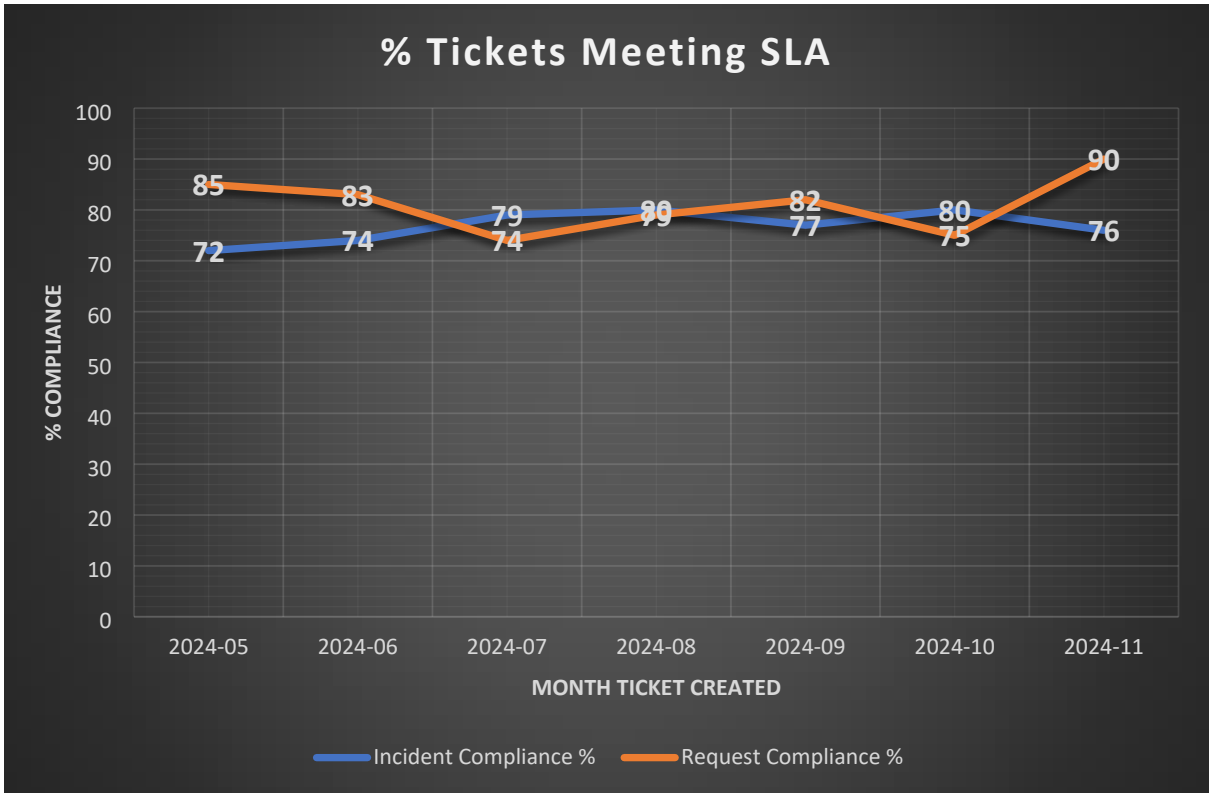


Figure 3 - SLA compliance by ticket for tickets closed as of 8th January.

Please note the data above represents compliance as of the 8th of January. This is the first month where we have offset our SLA reporting by a month to capture values once most tickets have been closed. This will minimise drift in reported statistics.

Requests Overall Compliance

Efforts to improve the compliance with requests continues with the service reaching 90% after a dip in resolving tickets created in October.

Incidents Overall Compliance

An improvement in incident compliance slightly decreased (4%). This suggests that the incident compliance is now averaging between 75% and 80%. The Client Services Lead will be working with the Service Desk to ensure that response SLAs are being met and tickets are being forwarded to support teams in the shortest time possible. This will provide support teams more time in the SLA timer.

The Client Services Lead and ICT Service Delivery Manager are currently reviewing best practice policies and processes. Updates to these policies and the effective management and ownership of tickets will help to improve proactive ticket management and improve SLA compliance.

Request Compliance Breakdown by Team

The graph below shows the level of compliance by different teams in the Digital Services. Compliance is not consistent across the teams, possibly identifying gaps in resource to meet demand within the set SLAs.

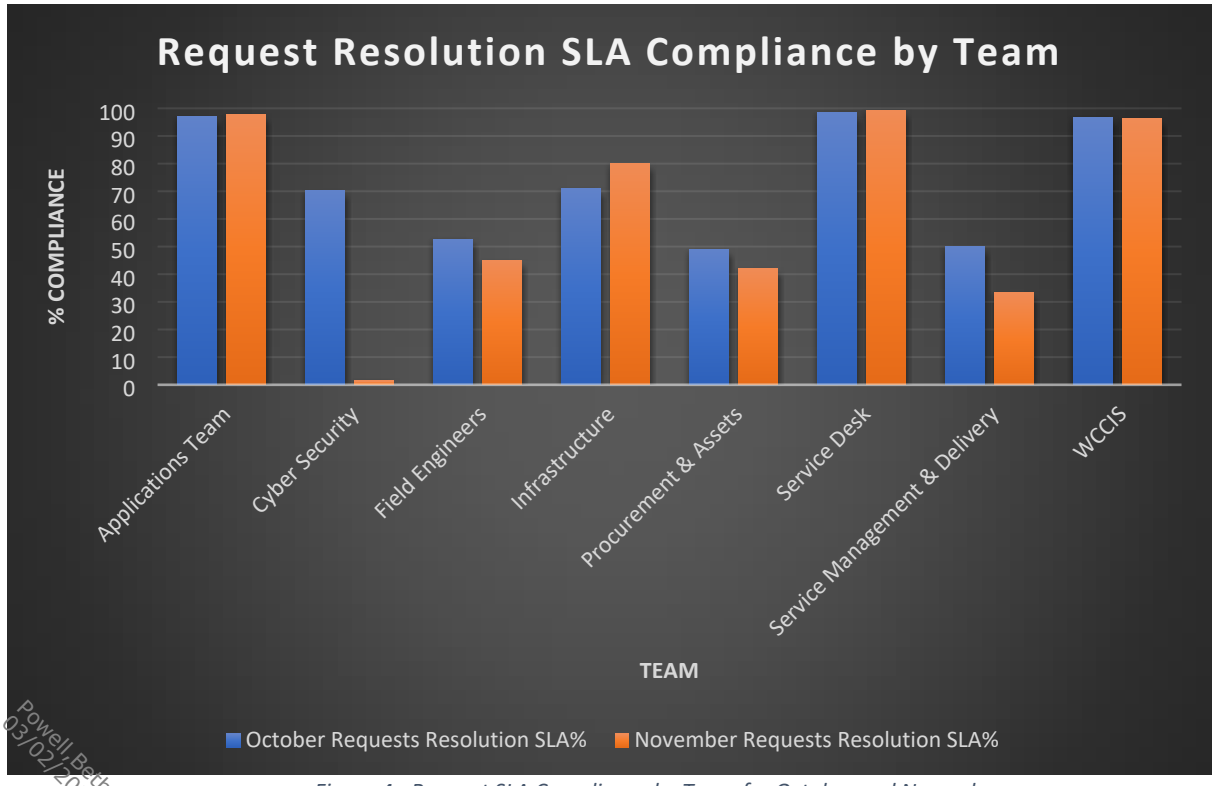


Figure 4 - Request SLA Compliance by Team for October and November

SLA Achievers (>90%)	Notable improvements in SLA (+10%)	Non-Compliant (<90%)
• Applications Team • Service Desk • WCCIS		• Cyber Security • Field Engineers • Infrastructure • Procurement & Assets • Service Management & Delivery

Despite process improvements, Procurement & Assets team compliance is still declining with a 6.53% decrease in November. Both Digital Support Officers now handle the same tasks, and Halo workflow has been upgraded for consistency. Ticket updates aligned with Oracle progress have reduced workload but haven't met the 5-business day SLA. The team are simply unable to keep up with the demand because of increased tickets in October and November did not see a corresponding drop in demand to allow capacity to resolve the worsened backlog.

Field Engineer SLA compliance has dropped by 8% after an initial improvement in October. This decrease has occurred as a backlog of tickets in Bronllys is resolved.

Incident Compliance Breakdown by Team

The graph below illustrates the compliance levels of various teams within Digital Services. There is a noticeable inconsistency in compliance across these teams, potentially highlighting resource shortages to fulfil demand within the established SLAs.
The Incident Response SLA refers to the time taken for a team to acknowledge receiving an incident reported via email or the portal. At this stage, the incident is prioritised and forwarded to the appropriate team, which must resolve the ticket within the resolution SLA.
The Incident Resolution SLA is the time taken for a team to resolve the issue reported. At this stage the ticket has been triaged. The total resolution time is the time that the team can provide a fix. If the ticket is escalated to a supplier or a meeting is arranged to discuss the issue, then the timer is placed on hold.

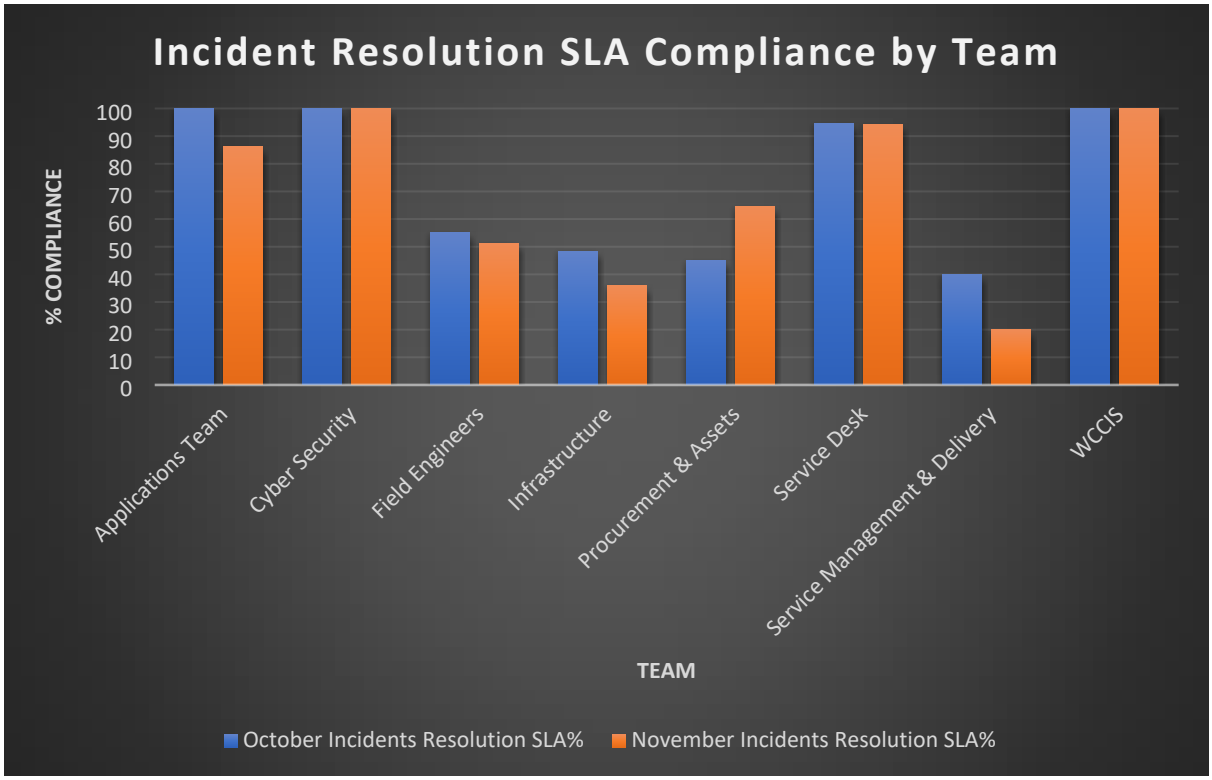


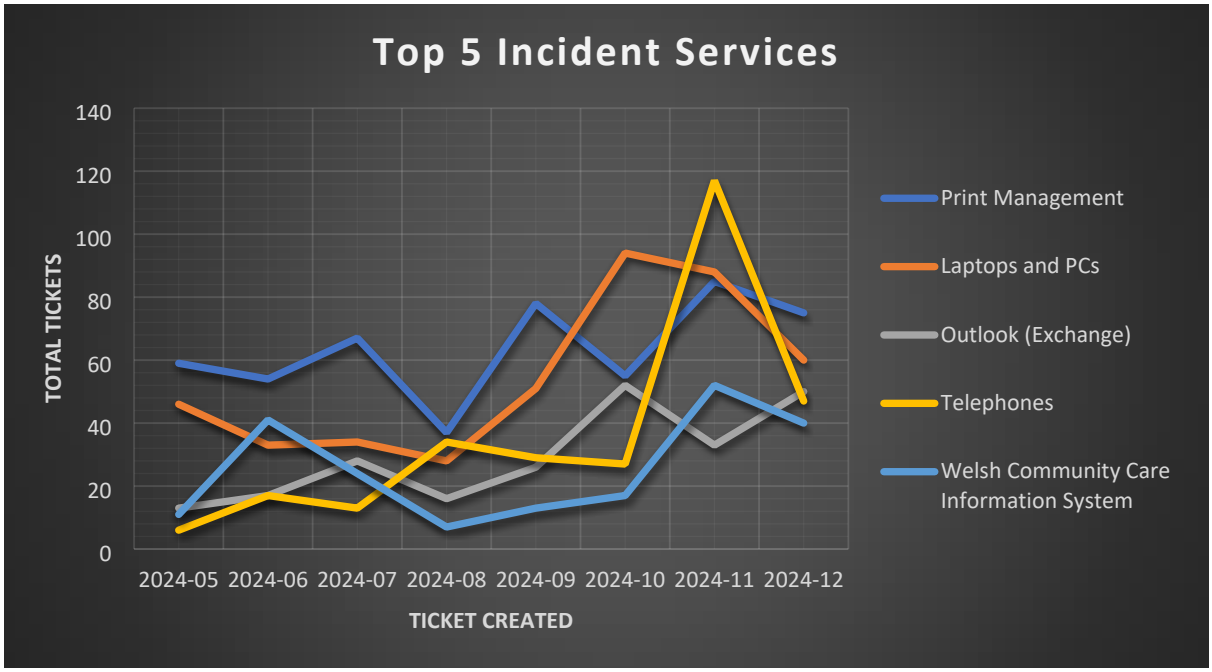
Figure 5 – Incident SLA compliance by team for November

SLA Achievers (>90%)	Non-Compliant (<90%)
• Cyber Security • Service Desk • WCCIS	• Applications Team • Infrastructure • Field Engineers • Procurement & Assets • Service Management & Delivery

The Applications Team saw a decrease of the SLA below the 90% target. This was driven by low numbers of incidents raised with the team. A total of 22 incident tickets were logged and 4 were not within SLA. An initial investigation concluded that errors in triaging the tickets resulted in the wrong SLA level being applied. For example, one ticket was rated as Major because a single user could only get WPAS to appear on a single screen. Work to update the IT Service Management Best Practice Policies and Processes will help to reduce these errors and will likely increase the number of requests being allocated as incidents. This increase will nullify the effect of small numbers of tickets not meeting SLA.

Top Incident Generating Services

Identifying the areas that cause incidents helps us target issues impacting our team. The graph below shows the areas generating the most incidents.



Print Management

Print Management continues to be a service that is consistently producing the highest number of incidents. 30% of the tickets are responses from the supplier that have not been matched to tickets. The ICT Service Delivery Manager will need to work with the Client Services Lead to identify the technical fix in Halo to avoid this duplication.

25.6% of tickets related to issues with scanning. The root cause of these issues is not apparent because the Service Desk are not providing information regarding the fix. Instead, they are simply reporting the issue has been resolved. This is true for much of the remaining 45% of tickets. This is not entirely the fault of the Service Desk team as the supplier does not provide a detailed closure report. This has already been escalated to the supplier and the Client Services Lead will be escalating again. The supplier has committed to improving the information provided and this is expected after they migrate to a new ICT Service Management tool.

Laptops and PCs

13% of tickets related to devices with Wi-Fi connectivity issues. These were usually due to devices losing their Wi-Fi certificate or falling off the network. During December there was a known issue with certificates being issued and this has been resolved. Incidents where devices have been not showing available on the network continue to be caused by device being retained by services rather than being provided to Digital Services for maintenance and storage.

The remainder of tickets related to niche issues with the devices themselves and can be loosely summarised as:

1. Performance issues (with some devices being online for over 27 days)
2. Driver issues with printers and microphones
3. Physical damage

Many of the performance issues related to older devices and those which have less than 16GB of RAM. These devices are being upgraded or refreshed where available.
Issues related to the TeamViewer pop up have been reduced to 1 reported incident.

Telephones

40% of calls in December related to issues with voicemails. These issues appear to be related to services still setting up their voicemail functionality after the migration of the phone system.

On Saturday 7th December there was a significant incident in Machynlleth Hospital that was caused by an extended loss of power to both the hospital and the local town. This occurred out of hours and during Storm Darragh. During this time, mobile networks and the telephony exchanges were also impacted.

The ICT resiliency systems maintained the internal network for over 30 minutes as per their design. However, these systems are not designed to sustain a network and are expected to maintain a consistent power supply. This protects ICT hardware from power surges and maintains service whilst an electrical grid swaps supplies. When power was restored there remained an issue with the telephony service. This was caused by an unanticipated failure in the network and required an extended period to investigate and provide a fix. Service was restored by 6pm on Sunday 8th December.

There were two incidents with the Brecon Switchboard. One of which occurred out of hours and was resolved in 30 minutes. Another incident appears to have been cause by users entering the wrong username to log in.
Remaining tickets are largely attributed to issues being made apparent after the migration to the new telephony system. These are being worked out as they are reported.

Outlook (Exchange)

39% of tickets relate to the issues of emails to Apogee not matching the correct record, as described in the Print Management commentary.
For the remaining 61%, many of the requests are general issues with using Outlook, i.e. failure of the Teams Add In, or relate to mailboxes reaching capacity. The latter is caused where users are choosing to delete significant numbers of emails, and this fills the recoverable items capacity. Instead, it is best to leave these emails in the Inbox or move them into another part of the

directory. The national retention rules will then clean up any emails that no longer need to be retained.

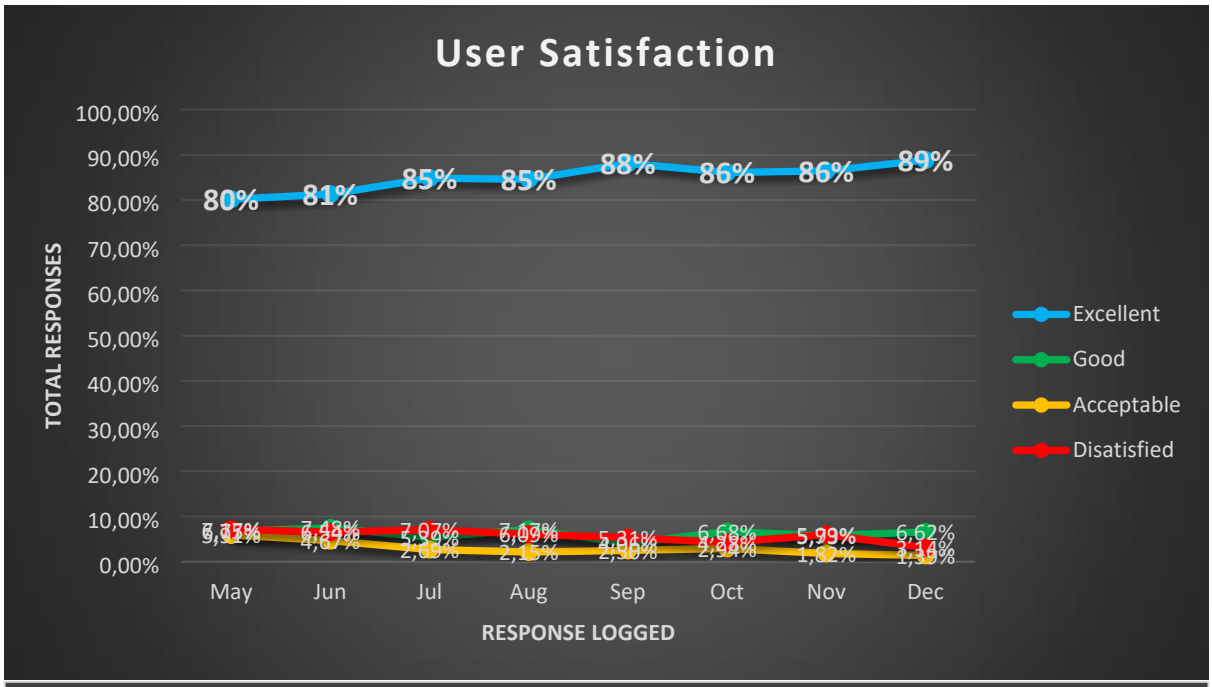
Welsh Community Care Information System (WCCIS)

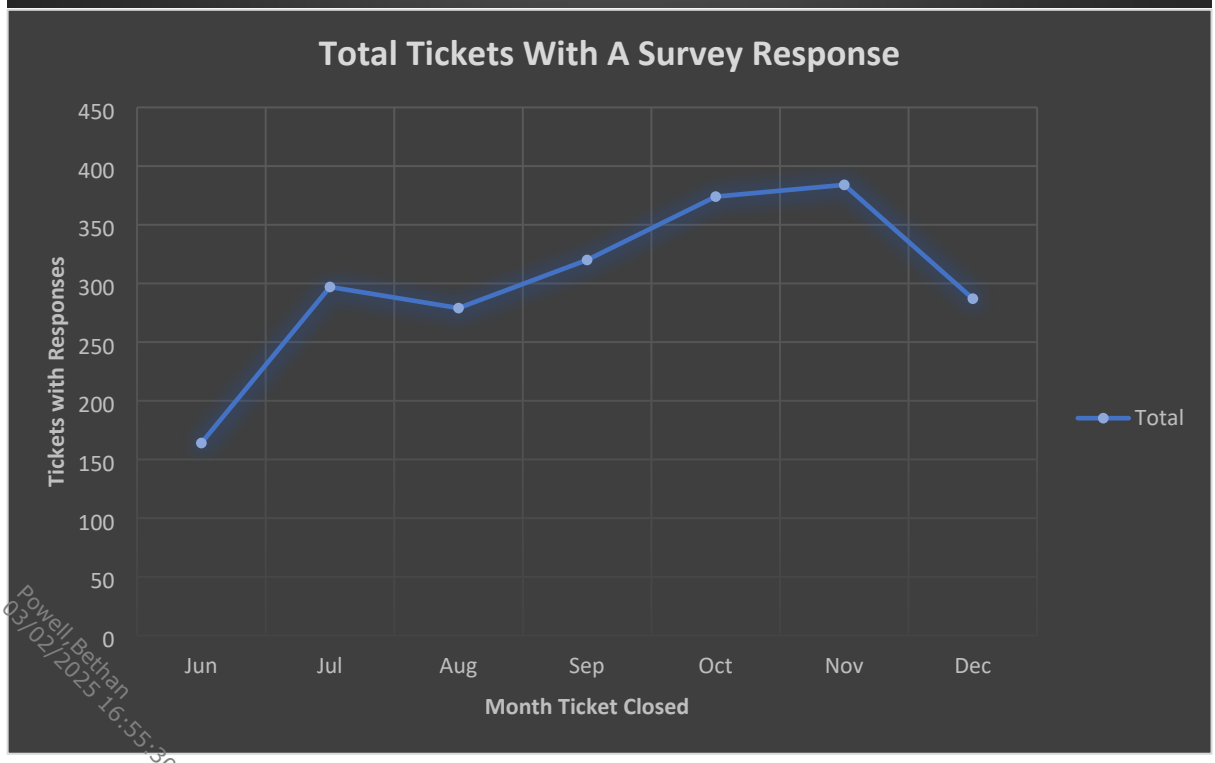
30% of tickets related to performance issues reported in WCCIS during December. The ICT Service Deliver Manager has a meeting booked with the WCCIS Service Improvement manager to look at improving the management of tickets incorrectly labelled as incidents.
Review of the Information Technology Infrastructure Library (ITIL) policies and processes will also address these data quality issues.

User Experience Monitoring

Digital Services are committed to ensuring that every interaction is positive. To achieve this, we invite staff to provide feedback on their experience throughout the ticket resolution process.

The data below demonstrates that most members of staff who took the time to rate their experience with digital as positive. Based on data from December, the overall trend is continual improvement in the proportion of users who rate the services as "Excellent".





Some examples of feedback:

Excellent
Rob was absolutely fabulous. So clear in direction and very kind explaining things clearly. Very grateful for his help, Amazing.
Thank you, Lauren, for your support. Always a pleasure calling IT team for support. Any issues are dealt with promptly by friendly, approachable staff.
I wish all departments were as quick at responding

Dissatisfied
i put in my request 11:24am its now 13:56 and the ticket is still not closed. it's a simple merging of notes
This does not answer the query as the site owners are not based at the DN team and requests are not being responded to - how do we change the site owners?
Ticket has not been resolved

The dissatisfied tickets were reviewed by the Client Services Lead and ICT Service Delivery Manager. Of the 4 dissatisfied tickets, 2 related to the requestor feeling the ticket was not resolved. Of these 2, one of them the agent provided adequate information to the user to enable them to access the VPN and assurance the VPN would work. For the second request, it was felt the requestor had had their primary concern resolved but were not empowered with knowledge to allow them to manage going forward.
1 of the 4 tickets related to a discrepancy in service provided in the new user process. This related to a student being provided access to services with the Health Board. This will be reviewed to identify potential improvements to the process, however generally student accounts should have limited access given their short lived nature.

The final request related to unrealistic expectations from the requestor who was expecting notes to be merged in a clinical system. Meeting these requests in the time expected is not sustainable.

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Powys Teaching Health Board

Agenda item: 5.9

Delivery and Performance Committee	**Date: 06 February 2025**
Subject:	**CAPITAL AND ESTATES COMPLIANCE UPDATE**
Approved and presented by:	Pete Hopgood, Executive Director of Finance, Capital and Support Services
Prepared by:	Associate Director Capital, Estates and Facilities
Other Committees and meetings considered at:	Informal Executive Committee - 30 January 2025

PURPOSE:

The paper has been prepared for the Delivery and Performance Committee to receive an update on the position in relation to Capital and Estates compliance and has been considered at Informal Executive Committee on 30 January 2025.

Issues of particular importance or risk are highlighted by exception.

RECOMMENDATION(S):

The Committee is asked to:

- **RECEIVE** the report and take **ASSURANCE** that the organisation has appropriate systems in place to monitor capital and estates compliance.

~~**Approve**~~**/Take Assurance**	**Discuss**	**Note**
Y	N	Y

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	✓	The work of the Estates team is focussed on providing a safe environment whilst Capital investments can support Transformation and the provision of a fit for purpose and modern estate.
2. Provide Early Help and Support	✓	
3. Tackle the Big Four	✓	
4. Enable Joined up Care	✓	
5. Develop Workforce Futures	✓	
6. Promote Innovative Environments	✓	
7. Put Digital First	✓	
8. Transforming in Partnership	✓	

EXECUTIVE SUMMARY:

CAPITAL: the paper will provide a brief update on Capital activity and an overview of assurance / audit status.

The all-Wales Capital Prioritisation Process introduced by Welsh Government (**WG**) in early 2024 has recently been concluded.

The Health Board has benefitted from an increase in WG capital allocation in 2024/25 with the committed Capital Resource Limit (**CRL**) at circa £13M, and with circa 56 schemes being delivered, this represents the largest capital delivery programme for many years. Slippage monies have recently been secured which added circa £900K and 8 projects to the pipeline. This will place pressure on the existing internal capital team resource to manage the step-change in activity within the financial year cycle.

Compliance status in relation to Internal Audit activity and findings in-year are included within the paper.

ESTATES: with 38% of the estate infrastructure predating 1948 and only 5% built post-2005, Estates maintenance remains a significant challenge. Addressing this will require substantial investment and risk-based programmes spanning several years across various compliance areas.

The paper outlines the Estates maintenance processes and describes the risk-based approach which has been adopted. Details of the means by which risk is identified and escalated is set out along with an overview of the healthcare documentation, NHS Wales Shared Services support structure, audit status and meeting / escalation arrangements.

CURRENT STATUS:

CAPITAL

General Update: the Welsh Government Capital Prioritisation Process was introduced in early 2024 in recognition of the pressure on NHS Capital with the 10-year spend profile seeing Health Boards anticipating future bids to be in the order of circa £6.7Bn, which is recognised as unaffordable in relation to the recurring £400M annual allocation. WG have now indicated that they can support the continuation of business case progression for two of the PTHB hospitals from core NHS Capital and are supporting a bid to Regional Partnership Board (RPB)

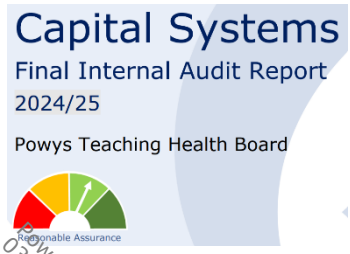
Future Funding update:

- **Targeted Estates Fund:** Welsh Government has announced £40M of funding per annum will be available in 2025/26 and 2026/27. The Targeted Estates Funding programme or **TEF** (previously known as EFAB) is intended to focus investment on key estates related risk issues for NHS organisations in Wales. The categories are outlined below. Health Boards have been asked to submit their bids by the end of January 2025. As in previous years a 30% health board contribution will be required from Discretionary Capital against each successful bid with 70% being provided by WG. As an example of expectation, WG use the population percentage as a rule of thumb for funding allocation, and PTHB could, therefore, expect circa £1.5M per annum which would require a proportional discretionary capital contribution.

Category		2025-26 £m	2026-27 £m
1	Infrastructure – All risks	18	18
2	Fire Safety	5	5
3	Mental Health	5	5
4	Decarbonisation	6	6
5	Infection Prevention Control	3	3
6	Decontamination	3	3
	Total	**40**	**40**

- **Discretionary Capital 2025/26 onwards**: Welsh Government has announced an increase to PTHB's Discretionary Capital allowance from £1.431M to £2.7M per annum. This provides the health board with more certainty on the 'base line' funding which is particularly beneficial for forward planning and resourcing the capital team which is funded through Capital funds. This will not only contribute to an increase in the number of discretionary capital schemes but will also allow the health board to deal with larger issues which were previously not possible due to the low level of available discretionary funding.
- **2025-2027 Capital Programme**: this is currently under development and is supported by the work of the Capital Control Group, which has a broad organisational membership and meets regularly to receive and assess work requests from across the health board - the project programme is approved by PTHB Board each year. There is a recognition, however, that the programme needs to be flexible to respond to emerging risks and changing priorities and has a further challenge in the current climate to support Transformation activity as the Better Together priorities for the health board become clearer.

Audit Status: NWSSP-Audit and Assurance Services / Internal Audit undertake regular audits of Capital activity - in 2024/25 this has included a Capital Systems audit on a selection of 10 discretionary capital schemes. A recommendation was noted to ensure construction contracts were enacted and signed for all projects and this finding has resulted in the strengthening of the PTHB Capital Procedures and more stringent requirements put in place for the professional consultant advisors to maintain adherence for future schemes. Internal Audit did note the continual improvement of governance for the Capital Team as part of the final audit report, which resulted in a Reasonable Assurance outcome:

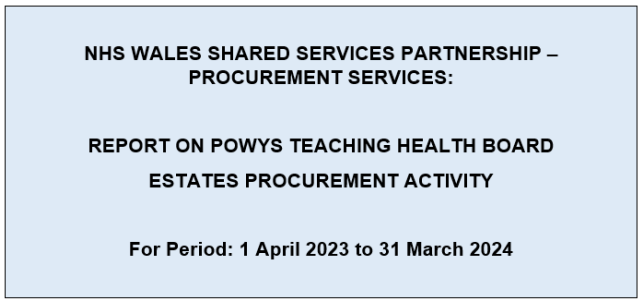


'Over the past few years, Capital and Estates have dedicated substantial time and effort to developing a structured control environment for their projects. This commitment has involved implementing a capital toolkit designed to enhance project

management and oversight. By establishing clear processes and standards, the department has aimed to ensure consistency and quality across all projects.'

A further NWSSP audit on the initial project investment of £3.0M for the Llandrindod Phase 2 scheme completed the Fieldwork stage in mid-January 2025 and is awaiting the production of the draft report.

Procurement: a compliance report is produced annually by NWSSP Procurement which reviews adherence to Standing Financial Instructions and general procurement regulations. The report includes a general overview of activity in period including both quotation and tender activity schedules and conformance reviews, single tender waiver review and a section on areas for action/improvement. The report is tabled at Innovative Environments Group and any actions identified are monitored in the monthly Procurement / Estates management meetings.


NHS WALES SHARED SERVICES PARTNERSHIP – PROCUREMENT SERVICES:

REPORT ON POWYS TEACHING HEALTH BOARD ESTATES PROCUREMENT ACTIVITY

For Period: 1 April 2023 to 31 March 2024

The report covers both Capital and Estates activity and compliance.

ESTATES

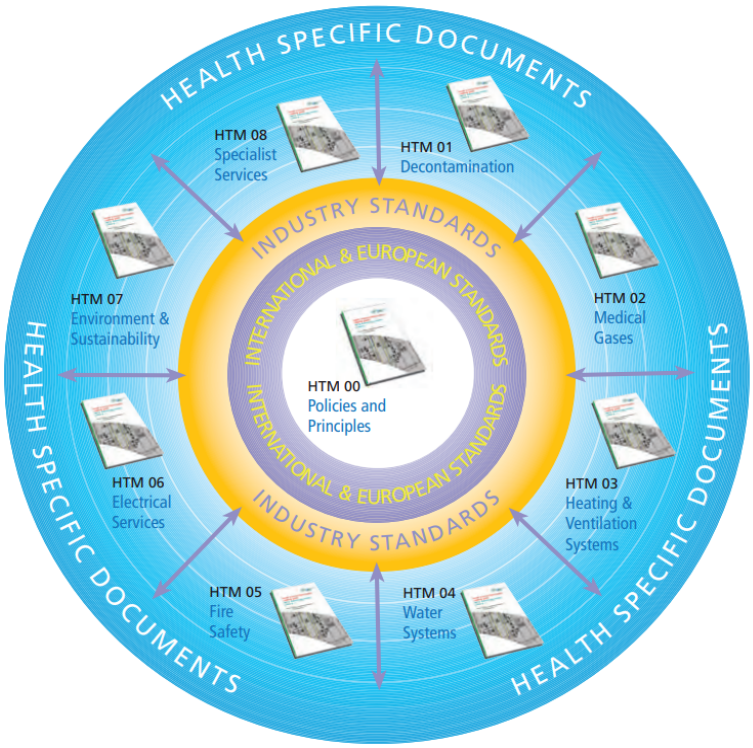
Background: with 38% of the estate predating 1948 and only 5% built post-2005, the workload and safe and compliant management of the PTHB estate remains a significant challenge. Addressing this will require substantial investment and support for risk-based programmes of activity spanning several years across various compliance areas, including fire safety, water hygiene, electrical systems, medical gases, ventilation, etc. Backlog Maintenance is estimated at approximately £73M. The revenue position is also under considerable strain, with energy cost pressures and reactive maintenance generated by failing infrastructure, plant and equipment related to the oldest and 'least new' estate in Wales.

Internal Audit raised concerns in their March 2024 'Limited Assurance' report on Estates Condition, highlighting a funding shortfall that could impact efforts to address the backlog maintenance and support future transformation. Following escalations at WG level about the ever-increasing backlog maintenance burden across NHS Wales, exceeding £1Bn for the first time a couple of years ago, and now reported to be £1.35Bn.

All Wales capital of £30M was made available as a one-off Backlog Maintenance fund for 2024/25 with 3.0M secured by PTHB to support improvement works to the front of Llandrindod Hospital. Several other high priority bids were registered and these will form the basis for future funding requests. PTHB were also successful in securing

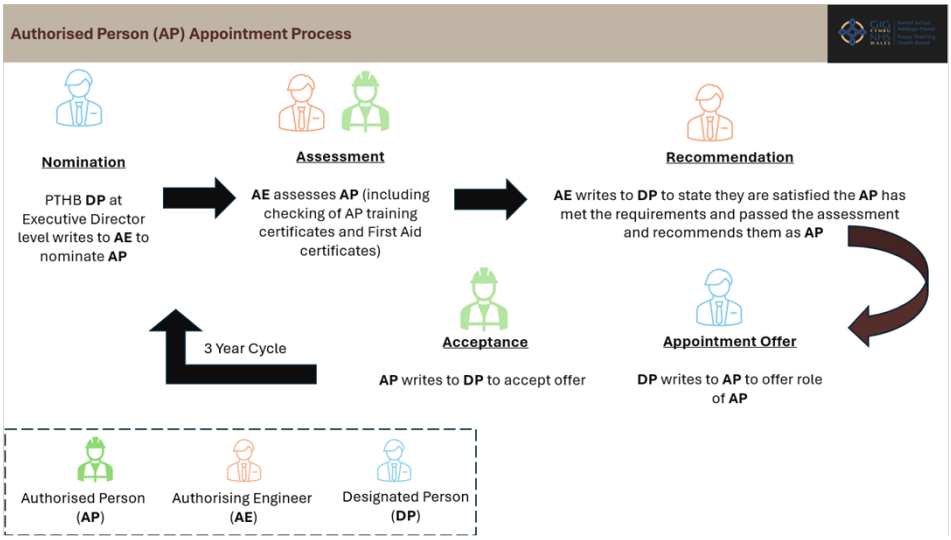
funding for several urgent projects via capital slippage to support improvement work to the Bronllys sewage treatment plant, asbestos removal in Brecon hospital, etc., which have helped to address backlog maintenance and compliance risks across the estate.

Compliance in a healthcare setting: Welsh Health Technical Memoranda (WHTMs) provide detailed guidance on the design, installation, and operation of specialised building and engineering technology in healthcare delivery. Healthcare providers must ensure effective governance arrangements are in place. The WHTM series offers best practice engineering standards and policies to support the management of this responsibility. These memoranda are supported by NHS Wales Shared Services Partnership - Specialist Estates Services (**NWSSP-SES**), which provides technical guidance and Authorising Engineer support for the defined disciplines.



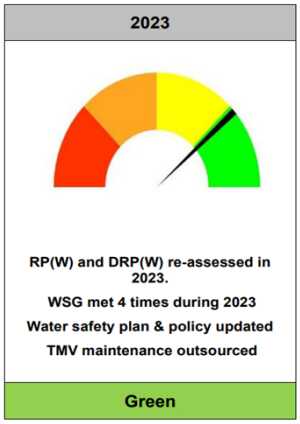
The Estate's team have appointed leads for each of the WHTM areas of activity, who are appropriately trained and qualified, with access for advice to the NWSSP-SES Authorising Engineers and technical team.

The HTM process is also underpinned by the appointment of Designated Persons at Executive Director level within the Health Boards – this is the Director of Nursing for Decontamination and the Director of Finance, Capital and Support Services for other disciplines. The Designated Person works in conjunction with the NWSSP-SES Authorising Engineer, who assesses the competence and experience of the Authorised Persons for the specific compliance areas and recommends appointment.



Audit and Assurance: in addition to providing technical guidance and support, NWSSP-SES undertake routine audits / Authorising Engineer Annual Reports for compliance activity. The most recent published audit reports are as follows:

Water: Substantial



Medical Gas: Reasonable

Ventilation: Reasonable

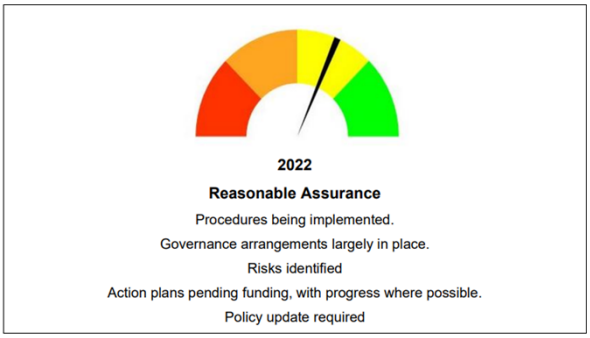


Figure 1- Compliance Rating

Decontamination: Reasonable

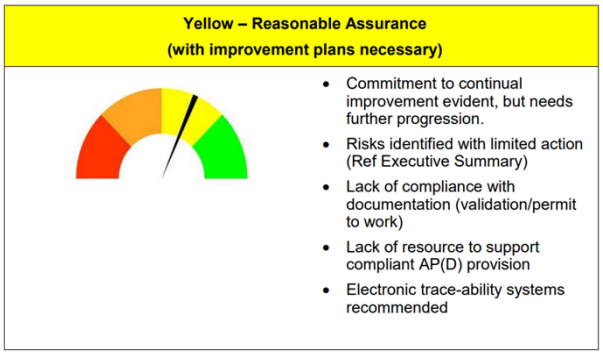
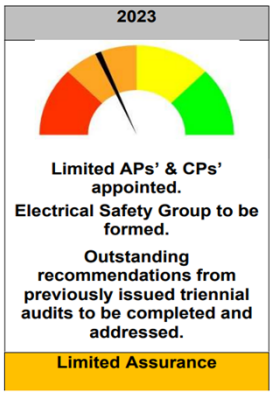


Figure 1 Overall Compliance Rating

Electrical: Limited



Electrical (Low Voltage – LV); Limited - the audits are conducted on a specific site and then processes reviewed on an overarching level. PTHB will always have an issue with the number of Appointed Persons and Competent Persons due to the resource levels and geography. In terms of the observations that led to a Limited Assurance,

the Electrical Safety Group has now been convened and the specific recommendations related to Ystradgynlais in relation to rubber matting, schematic drawings, signage, etc. have been addressed. Progress is reported at the Electrical Sub Group and Electrical Safety Group.

Fire: 'Independent Reviews of Fire Precautions' are conducted by the NWSSP-SES Senior Fire Safety Advisor are undertaken at a site level but are not assessed against the usual 'assurance' criteria; recommendations are addressed and monitored by the Estates Fire Sub Group and organisational Fire Safety Group which is attended by the Shared Services Senior Fire Safety Advisor. The Health Board also complete data returns annually to NWSSP-SES in relation to general fire criteria and separately on false fire alarm activations with the resultant data published by NWSSP-SES. Mid and West Wales Fire and Rescue Services (MWWFRS) additionally undertake a programme of site specific inspections with an outcome report and recommendations – example outcome letter for Knighton dated October 2024 as follows:

Gwasanaeth Tân ac Achub
Canolbarth a Gorllewin Cymru
Mid and West Wales
Fire and Rescue Service

The Regulatory Reform (Fire Safety) Order 2005 Letter of Fire Safety Matters Premises: Cottage View Residential Care Home, Knighton. *I visited your premises on 28th October 2024 and evaluated the fire safety provided. I am pleased to advise you that you showed adequate safety. However, I am of the opinion that you can improve that safety. The attached schedule sets out my suggested improvements. There is no time limit associated with this letter. I do not intend to return in connection with this visit.*

The Fire Safety Group now commissions an internally produced Annual Report based on a calendar year cycle and this provides an overview of status for this important compliance area – the report is shared at Innovative Environments Group (**IEG**) and as directed by IEG.

Asbestos: this is an important compliance area which is not supported by NWSSP-SES. Recognising this, the Policy update in 2022 required the production of an Annual Report for each calendar year to provide a status position on compliance. In addition, NWSSP Audit and Assurance has been asked to consider including asbestos as part of the Audit Plan for 2025/26 – failing this, an external commission will be made to undertake an independent audit to provide added assurance.

Other Compliance Activity: there are several other areas of Estates responsibility which can be classed as 'compliance' and which have statutory implications. There are several Estates technical sub groups which are in place to manage these additional topic areas and report into the Estates Compliance Group and Innovative Environments Group which is chaired by the Deputy Chief Executive / Director of Finance, Capital and Support Services:

- Radon
- Infrastructure: including boilers, lifts, etc.
- Health and Safety
- Buildings and Biodiversity

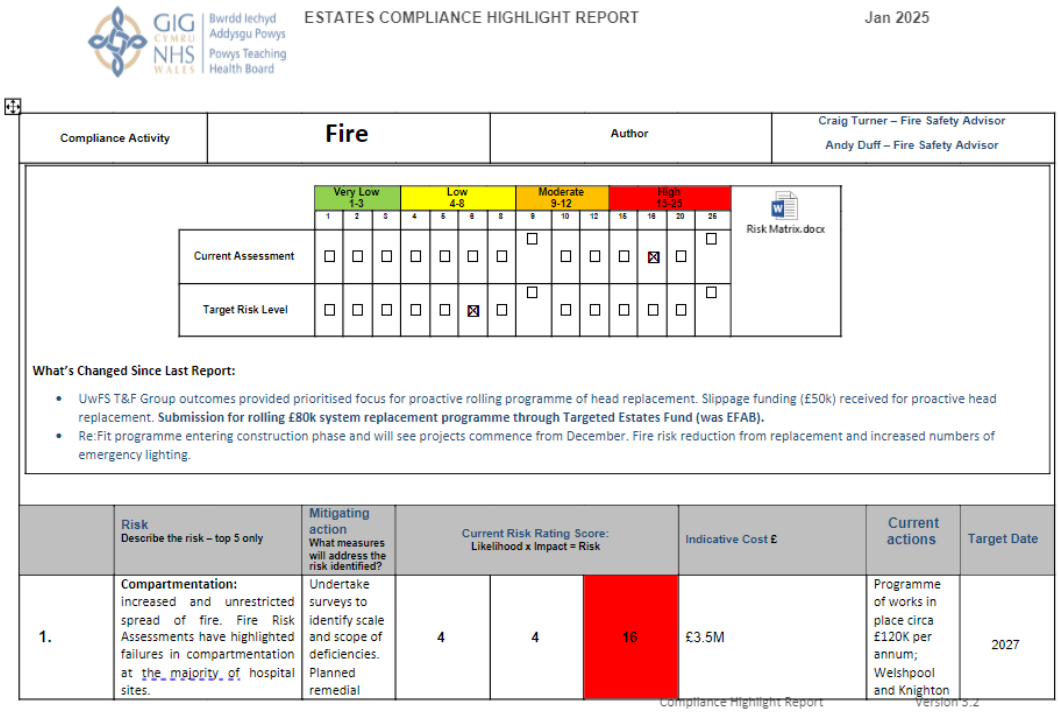
Planned Preventative Maintenance (PPM): is designed to monitor and maintain the safety, functionality and regulatory compliance of the estate within the healthcare setting. It involves regular inspections, scheduled maintenance and prompt action to address issues with building infrastructure and critical systems - by proactively maintaining assets, the PPM approach reduces the risk of unexpected failures, minimises costs and creates a resilient environment for both patients and staff.

NORTH POWYS ESTATES	
Week Commencing	22.12.24 (Week 52)
Week Ending	29.12.24

Building	PPM Jobs	Completed PPM Jobs	Incomplete PPM Jobs	Delivery Of Service
All Sites	1	1		100%
Brohafren Clinic	2	2		100%
Bryntirion Clinic	2	2		100%
Llanidloes Hospital	2	2		100%
Machynlleth Hospital	4	4		100%
Newtown Hospital	3	3		100%
Mochdre Industrial Unit	1	1		100%
Park Offices, Newtown	3	3		100%
Park St Clinic	2	2		100%
Welshpool Hospital	8	8		100%
Welshpool Clinic	3	3		100%
Ynys-y-Plant	2	2		100%
TOTALS	**33**	**33**		**100%**

Example - Planned Preventative Maintenance summary report

Adopting a risk-based approach to managing estates compliance: this involves prioritising maintenance and improvements across multiple competing portfolios based on the level of risk they pose to safety, regulatory adherence, and operational efficiency. The process begins with identifying and assessing risks associated with building infrastructure, equipment, and systems. These risks are reviewed by the compliance sub-groups, who evaluate them for severity and likelihood. Competing work streams, ranging from health and safety concerns to legal compliance, environmental impact, and patient care, are all considered in the risk assessment process. Critical areas that could have a significant impact on safety or compliance are prioritised, while lower-risk activities are addressed opportunistically / over time. This approach ensures that limited financial resources are allocated effectively, focusing on high-priority risks that could prevent system failures or safety breaches and support business continuity.



GIG CYMRU NHS WALES | Bwrdd Iechyd Addysgu Powys / Powys Teaching Health Board

ESTATES COMPLIANCE HIGHLIGHT REPORT Jan 2025

Compliance Activity	Fire	Author	Craig Turner – Fire Safety Advisor Andy Duff – Fire Safety Advisor

	Very Low 1-3			Low 4-8				Moderate 9-12			High 15-25			
	1	2	3	4	5	6	8	9	10	12	15	16	20	25
Current Assessment	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☐	☐
Target Risk Level	☐	☐	☐	☐	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐

Risk Matrix.docx

What's Changed Since Last Report:

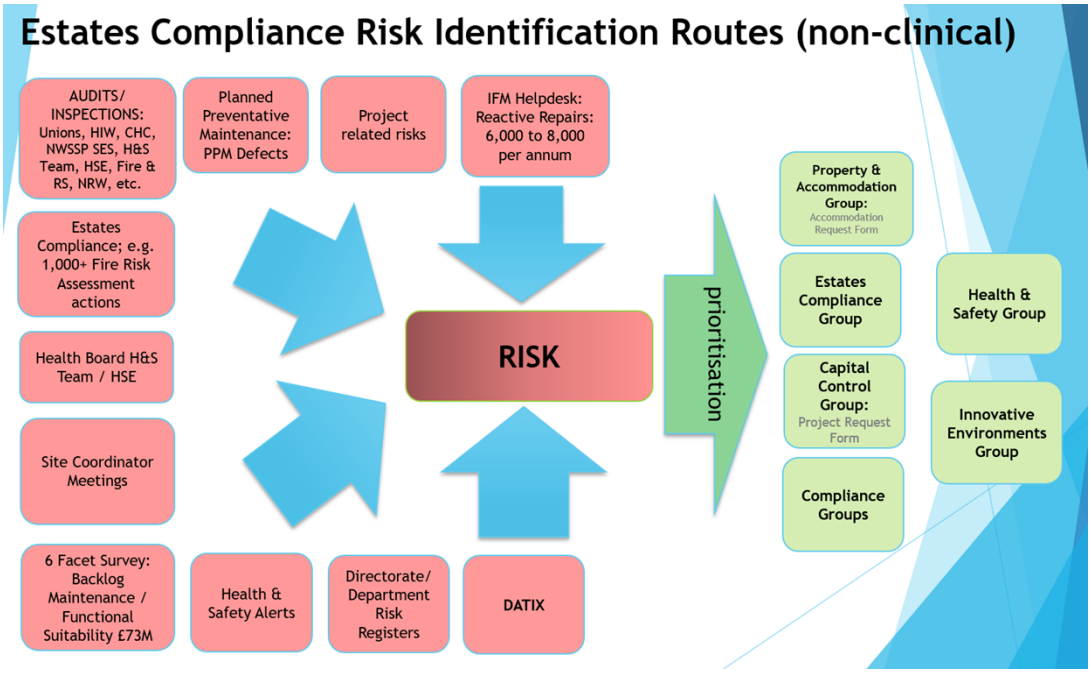
- UwFS T&F Group outcomes provided prioritised focus for proactive rolling programme of head replacement. Slippage funding (£50k) received for proactive head replacement. **Submission for rolling £80k system replacement programme through Targeted Estates Fund (was EFAB).**
- Re:Fit programme entering construction phase and will see projects commence from December. Fire risk reduction from replacement and increased numbers of emergency lighting.

	Risk Describe the risk – top 5 only	Mitigating action What measures will address the risk identified?	Current Risk Rating Score: Likelihood x Impact = Risk			Indicative Cost £	Current actions	Target Date
1.	**Compartmentation:** increased and unrestricted spread of fire. Fire Risk Assessments have highlighted failures in compartmentation at the majority of hospital sites.	Undertake surveys to identify scale and scope of deficiencies. Planned remedial	4	4	16	£3.5M	Programme of works in place circa £120K per annum; Welshpool and Knighton	2027

Compliance Highlight Report Version 5.2

Sample excerpt from Fire Highlight Report

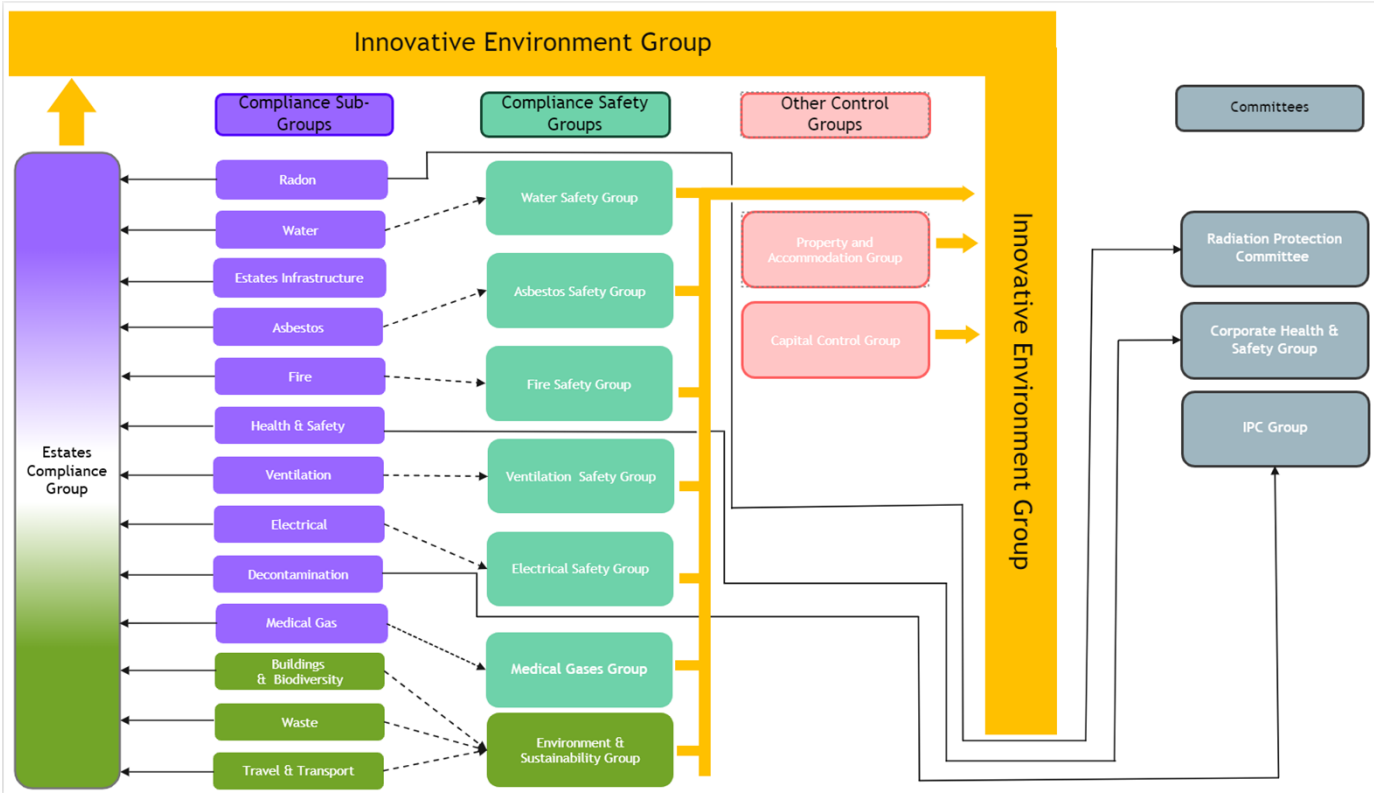
Estates Compliance Sub-Groups/Safety Groups: these groups are responsible for managing and monitoring risks related to building maintenance, health and safety, and regulatory compliance across the estate. Each sub-group focuses on specific compliance areas, such as fire safety, decontamination, asbestos, etc., by undertaking regular inspections and carrying out PPM's will identify potential hazards. Risks are evaluated based on severity and likelihood with Highlight Reports available for each compliance area of activity, with action plans developed to mitigate or resolve issues, i.e., utilising ringfenced capital funding, revenue funding or submitting a business case to WG. Findings are reported via safety groups in the case of Water, Ventilation, Medical Gas, Electrical and Asbestos, and then on to the Estates Compliance Group. Through continuous monitoring, periodic reviews the sub-groups contribute to maintaining a compliant, safe and effective estate while supporting the overall risk management strategy.



Reporting Structure: the Estates Compliance Groups / Sub-Groups report into the Estates Compliance Group which considers the Sub-Group Highlight Reports by exception and exercises a general overview of Estates activity. The Compliance Groups (as opposed to Estates technical Sub-Groups) have wider organisational membership and are generally attended by the NWSSP-SES Authorising Engineer to share NHS wide good practice, provide expertise, advice and an external perspective.

The Estates Compliance Group reports into the Innovative Environments Group which is chaired by the Deputy Chief Executive / Director of Finance, Capital and Support Services, has Executive membership and is supported by Director of NWSSP-SES to offer independent specialist advice to the group.

The Innovative Environments Group also receives reports from several other Estates and compliance related groups and reports by exception to the Executive Committee. The meeting structure for IEG is set out below.



Estates Compliance meeting structure reporting to Innovative environments Group

RISKS:

Capital Risks / Compliance:

- **Capital Investment Profile**: Internal Audit have commented on the strengthening of the Capital Procedures which provides a good assurance platform. The challenges arise due to the matching of suitable and experienced resource against the overarching investment profile, which has changed / increased in recent years, noting that the capital funding pays for the internal resource, which has to match the money that needs to be spent across multiple speciality areas. There are also significant fluctuations in activity levels through the individual financial year cycle, often with an influx of spend and activity towards the end of the period via WG slippage, etc. which increases the delivery pressures considerably.
- **Funding Sources**: the Health Board has historically received funding either via the allocation of discretionary capital or via business case submissions to All Wales Capital Funding (AWCF). In recent years the funding sources have become more diverse and complex with Regional Partnership Board IRCF funding which can only be made in conjunction with a partner public sector body via business case submissions, EFAB/TEF which have multiple targeted elements within the overarching fund, Primary Care / Third Party Developer projects for GP Practices, charitable / community funded schemes, etc.

- **Project Prioritisation**: as funding is secured or priorities change rapidly due to emerging operational risks (boiler failures, roof leaks, etc.), or respond to the requirements of Transformation activity, the capital programme needs to continue to be flexible in terms of prioritisation and reassessment / re-prioritisation as need demands, whilst also maintaining a suitable governance approach. Currently, visibility is via the Innovative Environments Group.

Estates Risks:

- **Aging Estate**: this is an overriding risk and is reflected in the Corporate Risk Register at level 16, a 'fit for purpose' estate. Funding and resource levels do not currently match the challenge which is expressed by the Backlog Maintenance burden of circa £73M across a geographically dispersed estate. The funding received in recent years has been used appropriately and has brought many of the compliance areas up to a reasonable level, but this reflects investments in older buildings which are not configured to deliver a modern healthcare service. The strategic investment in new estate / major reconfigurations of the existing estate is the best means of achieving compliance and delivering a fit for purpose estate, and this may ultimately mean a consolidation of hospital premises.

NEXT STEPS:

CAPITAL

- Delivery the Discretionary and EFAB and other capital schemes in financial year, within cost, time and quality constraints.
- Continue to support major project activity for North Powys, and Llandrindod Phase 2 via RPB, NHS Capital and other funding routes.
- Recruit additional resource within capital team to enable successful delivery of the step up in project activity whilst responding to fluctuations in capital investment.
- Respond to the Better Together outputs to develop an Estates Strategy to define the context and ambition for capital investment for the health board long term planning.

ESTATES

- Maintain risk-based approach across all sectors of activity, ensuring appropriate escalation and visibility of risk.
- Continue to seek sufficient funds and resource to support an active capital project agenda.
- Continue to review and support internal workforce and structure to manage risk and improvement activity.

IMPACT ASSESSMENT

This section must be completed for all strategic organisational decisions including approval of health board policies.

QUALITY:

	No impact	Negative	Positive	Both	
Safe	x				Capital and Estates Compliance is an underpinning / enabling activity
Timely	x				
Effective	x				
Efficient	x				
Equitable	x				
Person Centred	x				
Workforce	x				
Leadership	x				
Culture	x				
Information	x				
Learn, Improve, Research	x				
Whole Systems Approach	x				

EQUALITY:

	No impact	Negative	Positive	Both	
Age	x				Capital and Estates Compliance is an underpinning / enabling activity
Disability	x				
Gender reassignment	x				
Marriage / civil partnership	x				
Pregnancy / maternity	x				
Race	x				
Religion or Belief	x				
Gender	x				
Sexual Orientation	x				
Welsh Language	x				
Socio-economic status	x				
Social exclusion	x				
Carers	x				

RISK ASSESSMENT:

	Level of risk identified				
	Very Low (0-3)	Low (4-8)	Moderate (9-12)	High (15-25)	
Clinical			x		Capital and Estates Compliance is an underpinning / enabling activity – failures to meet compliance standards would be specific to the occurrence/s and could have a range of consequences. Most typically, impacts are indicated within the table.
Financial			x		
Corporate			x		
Operational			x		
Reputational			x		

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 5.10

Delivery and Performance Committee	**Date: 6 February 2025**
Subject:	**CORPORATE RISK REGISTER (D&P COMMITTEE)**
Approved and presented by:	Director Of Corporate Governance/Board Secretary
Prepared by:	Corporate Governance Assurance and Risk Officer
Other Committees and meetings considered at:	Executive Committee – 22 January 2025 Board – 29 January 2025

PURPOSE:

To present the Committee version of the Corporate Risk Register (CRR) to support the Committees review and seeking assurance in relation to the risks identified to the delivery of Powys Teaching Health Board's (PTHB) strategic objectives, the controls in place to manage these risks and their efficacy.

The risks provided are the ones agreed by the Board as within the remit of the Committee. The Committee Risk Register is based upon the Corporate Risk Register (CRR) considered by the Board on the 29 January 2025.

RECOMMENDATION(S):

The Delivery and Performance Committee is asked to:

- **RECEIVE** and **DISCUSS** the corporate risks within the Committee's remit and any relevant issues.
- **TAKE ASSURANCE** that risks are being managed in line with the Risk Management Framework.

Two of the strategic risks (008 and 012) will be considered in-committee due to the confidential and sensitive nature of the actions and controls. These risks relate to Cyber and Digital Programmes.

Approve/Take Assurance	Discuss	Note
Y	Y	Y

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	Y	

2. Provide Early Help and Support	Y	The Corporate Risk Register links to all of the Health Board's objectives by identifying risks that could impact on delivery or achievement.
3. Tackle the Big Four	Y	
4. Enable Joined up Care	Y	
5. Develop Workforce Futures	Y	
6. Promote Innovative Environments	Y	
7. Put Digital First	Y	
8. Transforming in Partnership	Y	

EXECUTIVE SUMMARY:

The Committee Risk Register draws together relevant risks from the Corporate Risk Register (CRR) to provide a summary of the significant risks to delivery of the Health Board's strategic objectives.

The Corporate Risk Register (CRR) is a cornerstone of the Board Assurance Framework (BAF) and is the central repository for risks to the delivery of PTHB's strategic objectives.

There are 12 risks on the corporate register; 6 of those risks fall within the remit of this Committee and are there provided as the Corporate Risk Register (D&P Committee).

The Board received a report at its meeting on the 29 January 2025 and supported the change in risk score for risk CRR001 (financial forecast) which has increased from 16 (L4 x I4) to (L5 x I4) 20, due to scale of remedial actions required to achieve the Financial Plan.

Appendix 1 (Corporate Risk Dashboard) shows a summary of the risks and the heatmap of risk ratings.

Appendix 2 provides the detail of risks to be considered at the in public meeting – provided as appended documents to this report.

Appendix 3 provides the detail of risks (008 and 012) to be considered at the in-committee meeting - – provided as appended documents to the in-Committee papers.

BACKGROUND AND ASSESSMENT

The Health Board approved the Board Assurance Framework (BAF) in May 2024, linked here - CGP 014 Board Assurance Framework May 2024
The Corporate Risk Register (CRR) is a cornerstone of the Board Assurance Framework (BAF) and is the central repository for risks to the delivery of the organisation's strategic objectives.

The CRR provides a summary of the significant risks to the delivery of the Health Board's strategic objectives. Corporate risks also include risks that are widespread beyond the local area (e.g. directorate), and risks for which the cost of control is significantly beyond the scope of the local budget holder.

Risk owners submit updated risk information to the Risk and Assurance Group (RAG) for review, check and challenge. The RAG then makes recommendations to the Executive Committee on amendments to risk scores or assurance ratings. The RAG can also escalate risks from Directorate Risk Registers to the Executive Committee, which is ultimately responsible for recommending the inclusion of risks in the CRR for Board approval.

The Boards risk appetite has been embedded into the CRR and work is underway to review and moderate the assurance ratings of controls to agree a consistent approach to assessing this which removes a degree of subjectivity from risk owners. The RAG will play an instrumental role in helping to achieve.

The detail related to Risk CR008 and CRR012 has been provided to the Committee for consideration in a closed session (in-committee) due to the confidential nature of some aspects of the risk management actions and controls.

ROLE OF THE COMMITTEE:

Board Committees have a vital role in supporting Senior Risk Owners and the organisation more broadly to seek assurance on the ongoing development and management of corporate risks.

The corporate risks relevant to the Committee will be provided at each meeting, the Committee is asked to consider these in their own right and to consider them alongside relevant agenda items through the cycle of Committee business.

Feedback from Committee members will be considered by the executive lead (senior risk owner) for each risk with the relevant staff and any changes will be reflected in the next risk reporting cycle update.

NEXT STEPS:

The Committee will continue to seek assurance on the ongoing development and management of the relevant corporate risks as set out above.

The next updated version of the Corporate Risk Register is due to be presented to the Board on 26 March 2025.

Appendix 1 - Delivery and Performance (D&P) Committee Risk Register – Heat Map

There is a risk that…

Private Risk (circulated to Members only)		• CRR 008 A cyber-attack results in significant disruption to services and quality of patient care (Risk Score: L5 x I4 = 20) • CRR 012 - National Digital Programmes do not always meet Powys requirements (Risk Score L4 X I4 = 16)					
Impact	**Catastrophic**	**5**					• CRR 002 The Health Board fails to manage its financial resources in line with statutory requirements over a three-year period 2024-2027. • CRR 008 A cyber-attack results in significant disruption to services and quality of patient care. • CRR 001 The Health Board fails to deliver its financial forecast and savings target for the current financial year (2024/25)
	Major	**4**				• CRR 003 The Health Board fails to adequately allocate resources and execute actions to deliver transformation, relevant reconfiguration, and longer-term service sustainability, leading to improved health outcomes / experience and reduce for citizens of Powys.	

						• CRR 009 The care provided in some areas is compromised due to the health board's estate being not fit for purpose. • CRR 012 - National Digital Programmes do not always meet Powys requirements	
	Moderate	**3**					
	Minor	**2**					
	Negligible	**1**					
			1	**2**	**3**	**4**	**5**
			Rare	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
			Likelihood				

Risk Lead	Risk ID	Main Risk Category	Risk Description There is a risk that:	SCORE (Likelihood x Impact)	Board Risk Appetite	Risk Target	At Target ✓/✗	Lead Board Committee
ED FC&SS	CRR 001	**Financial Sustainability**	The Health Board fails to deliver its financial forecast and savings target for the current financial year (2024/25).	**5 X 4 = 20**	Open	8	x	Delivery and Performance

Risk Lead	Risk ID	Main Risk Category	Risk Description There is a risk that:	SCORE (Likelihood x Impact)	Board Risk Appetite	Risk Target	At Target ✓/✗	Lead Board Committee
ED FC&SS	CRR 002	Financial Sustainability	The Health Board fails to manage its financial resources in line with statutory requirements over a three-year period 2024-2027.	**5 x 4 = 20**	Open	8	x	Delivery and Performance
ED P&C	CRR 003	Financial Sustainability	The Health Board fails to adequately allocate resources and execute actions to deliver transformation, relevant reconfiguration, and longer-term service sustainability, leading to improved health outcomes / experience and reduce for citizens of Powys.	**4 x 4 = 16**	Open	8	x	Delivery and Performance
ED AHPHS&D	CRR 008	Performance and service sustainability	A cyber-attack results in significant disruption to services and quality of patient care.	**5 x 4 = 20**	Cautious	12	x	Delivery and Performance
ED FC&SS	CRR 009	Quality	The care provided in some areas is compromised due to the health board's estate being not fit for purpose.	**4 x 4 =16**	Minimal	9	x	Delivery and Performance

Risk Lead	Risk ID	Main Risk Category	Risk Description There is a risk that:	SCORE (Likelihood x Impact)	Board Risk Appetite	Risk Target	At Target ✓/✗	Lead Board Committee
ED AHPHS&D	CRR 012	**Digital and Transformation**	National Digital Programmes do not always meet Powys requirements	**4 x 4 = 16**	Cautious	4	No	Delivery and Performance

KEY:

Risk Appetite Descriptors and Categories

Risk Appetite	Description
Averse	Avoidance of risk and uncertainty in achievement of key deliverables or initiatives is key objective. Activities undertaken will only be those considered to carry virtually no inherent risk.
Minimal	Preference for very safe business delivery options that have a low degree of inherent risk with the potential for benefit/return not a key driver. Activities will only be undertaken where they have a low degree of inherent risk.
Cautious	Preference for safe options that have low degree of inherent risk and only limited potential for benefit. Willing to tolerate a degree of risk in selecting which activities to undertake to achieve key deliverables or initiatives, where we have identified scope to achieve significant benefit and/or realise an opportunity. Activities undertaken may carry a high degree of inherent risk that is deemed controllable to a large extent.
Open	Willing to consider all options and choose one most likely to result in successful delivery while providing an acceptable level of benefit. Seek to achieve a balance between a high likelihood of successful delivery and a high degree of benefit and value for money. Activities themselves may potentially carry, or contribute to, a high degree of residual risk.
Eager	Eager to be innovative and to choose options based on maximising opportunities and potential higher benefit even if those activities carry a very high residual risk.

RISK APPETITE	
Category	**Appetite for Risk**
Safety	Averse
Quality	Minimal
Regulation and Compliance	Cautious
Reputation and Public Confidence	Cautious
Performance and Service Sustainability	Cautious
Financial Sustainability	Cautious
Workforce	Cautious
Partnerships	Open
Innovation and Strategic Change	Open

Executive Lead:	
CEO	Chief Executive
DPCCMH	Director of Primary, Community Care and Mental Health
DoNM	Director of Nursing and Midwifery
DFIIT	Director of Finance, Information and IT
MD	Medical Director
DPH	Director Public Health
DWOD	Director of Workforce and OD
DoTHS	Director of Therapies and Health Sciences
DPP	Director of Planning and Performance
BS	Board Secretary
DoE	Director of Environment

Risk Scoring

LIKELIHOOD	IMPACT				
	Insignificant 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
Almost Certain 5	5	10	15	20	25
Likely 4	4	8	12	16	20
Possible 3	3	6	9	12	15
Unlikely 2	2	4	6	8	10
Rare 1	1	2	3	4	5

Very Low	1-3	Low	4-8	Moderate	9-12	High	15-25

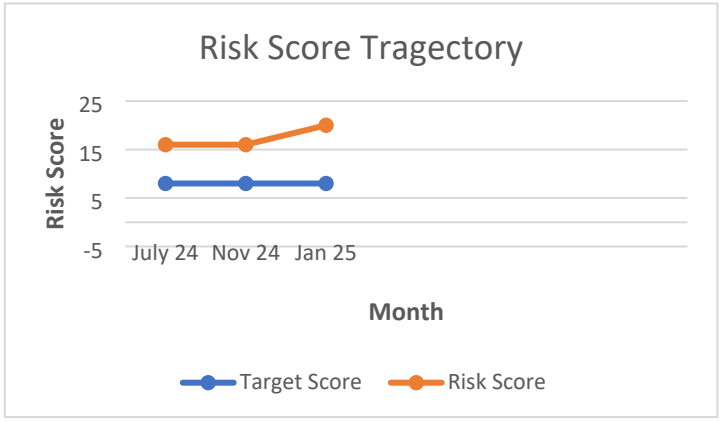
CRR 001 **Risk that:** The Health Board fails to deliver its financial forecast and savings target for the current financial year (2024/25)	**Executive Lead:** Executive Director of Finance, Capital and Support Services **Assuring Committee:** Delivery and Performance Committee
Risk Impacts on: Organisational Priorities underpinning all objectives	**Date last reviewed:** January 2025
Risk Category: Financial and Sustainability	**Boards Risk Appetite:** Open

Risk Rating (likelihood x impact):

Inherent: 4 x 4 = 16

Current: 5 x 4 = 20

Target: 2 x 4 = 8



Date added to the risk register.
June 2024

Source of risk:
Financial Plan

Rationale for current score:

- Financial planning for 2024/25 has identified that the THB will have a significant deficit.
- At a Board meeting in May, the Board approved a revised financial plan for 2024/25, which aims to achieve a financial deficit of £22.948m. The Plan includes an ambitious recurrent £9.9m savings target.
- Notification of £7.2m additional funding for 2024/25.
- A pipeline of schemes and ideas has also been developed, which will lead to further tangible schemes being implemented to enable the £9.9m target to be achieved.
- At Month 7, savings target forecast to be achieved, but significant risks to achieving the financial plan.
- The THB forecasts that it can manage its capital expenditure within the capital allocation.

	Controls (What are we currently doing about the risk?)	Sources of Assurance	Level of Assurance	Highest Assurance provided to:
7.1	Clear Financial Plan approved by Board of £22.948m, revised to £15.770m.	Plan approved by Board	Substantial	Board
7.2	Additional control – CEx and DoF meeting regularly with Executive Directors individually only focussed on	Feedback to Executive Committee	Reasonable	Board

	Financial performance.			
7.3	Risks and Opportunities – focus and action to maximise opportunities and minimise / mitigate risks.	Plan Management	Reasonable	Board
7.4	HB wide Group established for Variable Pay, identified leads and clear expectation re delivery. Variable pay, CHC and Commissioning regular deep dive areas of focus at D&P Committee to track actions to improve.	Reports to Executive and D&P Committee	Reasonable	Board
7.5	Regular communication and reporting to Welsh Government and NHS Executive (Financial Planning and Delivery Directorate) regarding the impact of pressures and impact on Financial Plan and underlying position.	Monthly Meetings and reporting in line with Escalation plan.	Reasonable	Board

Mitigating Actions (What more will we do?)

Action	Lead	Action update	Deadline	Action on Target
The capacity, capability and sustainability of the Finance Team is being re-assessed given the step change in the financial challenges facing the organisation and the increased external scrutiny.	DFC&SS	Review taking place with any identified capacity issues to be identified with prioritisation completed to stop actions where needed or additional resource case completed.	31/07/24	Completed
		Post of assistant FBP recruited to.	31/10/24	
Revisit the assessment of cost pressures in the Financial Plan for 2024/25.	DFC&SS	Under constant review to ensure latest forecast is as accurate as possible with action taken to offset pressures where possible.	Ongoing	Ongoing

Consider whether saving schemes can achieve more in 2024/25.	DFC&SS	Under constant review and all areas encouraged to develop a pipeline of ideas re improved efficiency. Note Bright Ideas, Opportunities Group and Sustainability Group.	Ongoing	Ongoing
Increase focus on longer term efficiency and sustainability (value) and balance with in year delivery as needed for plan. Value Based Healthcare and Sustainable Model Programme Boards established.	DFC&SS/DWOD	Under constant review – Sustainability Group, Value Based Healthcare approach and action as per Route Map to Sustainability (Better Together, ASM).	Ongoing	Ongoing
Current Risk Rating		**Update including impact of actions to date on current risk score**		
4 x 4 = 20		Increased to a score of 20, due to scale of remedial actions required to achieve Financial Plan.		

CRR 002 **Risk that:** The Health Board fails to manage its financial resources in line with statutory requirements over a three-year period 2024-2027.	**Executive Lead:** Executive Director of Finance, Capital and Support Services **Assuring Committee:** Delivery and Performance Committee
Risk Impacts on: Organisational Priorities underpinning all objectives	**Date last reviewed:** January 2025
Risk Category: Financial and Sustainability	**Boards Risk Appetite:** Open

Risk Rating (likelihood x impact):

Inherent: 4 x 5 = 20

Current: 4 x 5 = 20

Target: 2 x 4 = 8

Date added to the risk register.
June 2024

Source of risk:
Financial Plan

Rationale for current score:

- Following receipt of additional funding of £7.2m the 2024/25 plan has reduced from a £22.948m deficit to a £15.770m deficit.
- The Plan includes an ambitious recurrent £9.9m savings target. This is not currently being fully achieved on a recurrent basis.
- The Health Board is experiencing greater cost pressures than its recurrent mitigating actions and additional funding can contain. This is leading to an increase in its underlying deficit.
- The scale of this deficit against annual expenditure of circa £460m makes it probable that the organisation will not be able to comply with its statutory duty to breakeven for some time.

Controls (What are we currently doing about the risk?)	Sources of Assurance	Level of Assurance	Highest Assurance provided to:
7.1 Clear Financial Plan included in revised IMTP Submission with recurrent mitigating actions of £9.9m.	Plan approved by Board	Reasonable	Board

7.2	Additional control - Introduced joint CEO and FD finance only focussed meetings with each Exec Director individually.	Regular meetings and agreed action monitoring	Reasonable	Board
7.3	Risks and Opportunities – focus and action to maximise opportunities and minimise / mitigate risks.	Plan Management	Reasonable	Board
7.4	Group established for Variable Pay, identified leads and clear expectation re delivery, these groups will have a short and longer-term focus for delivery. Variable Pay, CHC and Commissioning regular deep dive areas of focus at D&P Committee to track actions to improve.	Reports to D&P Committee	Reasonable	Board
7.5	Investment Benefits Group to increase its focus on benefits realisation alongside supporting the VBHC approach.	Delivering VFM, improving efficiency and sustainability, report to Executive Committee	Reasonable	Board
7.6	Regular communication and reporting to Welsh Government and NHS Executive (Financial Planning and Delivery Directorate) regarding the impact of pressures on Financial Plan and underlying position.	Monthly Meetings and reporting in line with Escalation plan.	Reasonable	Board
7.7	An organisation wide group of AD/DDs has been established to identify actions to achieve recurrent savings and financial sustainability (Route Map to Sustainability).	Report to Exec Committee and Strategic Change Board.	Reasonable	Board

Mitigating Actions (What more will we do?)

Action	Lead	Action update	Deadline	Action on Target
Executive Directors are focussed on delivery of £9.9m recurrent mitigating actions targeted for 2024/25.	DFC&SS	Reported regularly to Board and Exec Committee and D&P	Ongoing	Ongoing

Revisit the assessment of cost pressures in the Financial Plan for 2024/25.	DFC&SS	Under constant review to ensure latest forecast is as accurate as possible with action taken to offset pressures where possible.	ongoing	Ongoing
As part of financial planning, an organisation wide group of AD/DDs has been established to identify actions to achieve recurrent savings and determine Routemap to Financial sustainability.	DFC&SS	Group reports into Strategic Change Board. There are two temporary service changes being engaged upon.	Ongoing Board decision in October	Ongoing
Current Risk Rating		**Update including impact of actions to date on current risk score**		
4 x 5 = 20		Executives focussed on delivery of £9.9m recurrent mitigating actions targeted for 2024/25. Strategic Change Board has been established to identify actions to achieve financial sustainability.		

CRR 003 **Risk that:** the Health Board fails to adequately allocate resources and execute actions to deliver transformation, relevant reconfiguration, and longer-term service sustainability, leading to improved health outcomes/experience for citizens of Powys.	**Executive Lead:** Executive Director of Finance, Capital and Support Services & Director of Strategic Improvement and Transformation **Assuring Committee:** Delivery & Performance Committee
Risk Impacts on: Organisational Priorities underpinning all WBOs	**Date last reviewed:** January 2025
Risk Category: Financial Stability	**Board's Risk Appetite:** Open

Risk Rating (likelihood x impact): Inherent: 4 x 4 = 16 Current: 4 x 4 = 16 Target: 2 x 4 = 8		**Rationale for current score:** • PTHB achieved the financial plan agreed with Welsh Government, ending the 2023/24 year with a deficit of £12m. The financial plan for 2024/25 is to end the year with a £22.9m financial deficit, which requires savings of £9.9m to be achieved, reduced to £15.8m following additional funding of £7.2m. • Lack of data re Patient Outcomes and Patient Experience to support understanding of Powys patients' care and treatment. • Value Based Healthcare approach introduced, but not yet embedded into financial plan and budget allocation fully. • Differences between the Welsh and English systems for commissioning inhibit reallocation of resource to the most appropriate parts of the pathway.
Date added to the risk register. September 2022		
Source of risk: Financial & data analysis		

Controls (What are we currently doing about the risk?)		**Sources of Assurance**	**Level of Assurance**	**Highest Assurance provided to:**
3.1	Value Based approach in place, including cross-cutting Value Based Health Care programme, with Value Based approach embedded in the IMTP focused on outcomes,	• Value Based Health Care programme plan and	Reasonable	Executive Director of Finance,

	experience and cost and agreed approach to embed an organisational understanding of value from induction through to leadership development	minutes (including those from relevant subgroups) • NHS Performance Framework returns (twice per annum) in relation to embedding Value Based Health and Care within organisational strategic plans and decision-making processes		Capital, and Support Services (as Co-Chair of the PTHB Value Based Health Care Programme)
3.2	Improving the collection and analysis of Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs) for Powys patients	• CIVICA in place for the collection of PROMs for patients treated in Powys. • Links made with commissioned providers to collect PROMs and PREMs for Powys patients treated out of county. • PTHB Value Based Health Care programme developing a business case for procurement of a PROMs platform for Powys, in line with other Welsh health boards and national requirements. – *paused given other priorities at present time*	Reasonable	

3.3	Transformation programmes in place, in line with PTHB IMTP Strategic Priorities, to provide the capacity to deliver the transformational deliverables required	• Transformation updates provided to Executive Committee • Programme plans, minutes etc from the North Powys Wellbeing Programme, Frailty & Community Model incorporating the Six Goals for Urgent & Emergency Care Programme, Planned Care & Diagnostics Programme, Mental Health Transformation Programme, Digital Transformation Programme.	Reasonable	Executive Committee
3.4	Strategic Change programme implementing temporary service changes to support financial sustainability	• Strategic Change Case for Change documents • Reporting into SC Board, Executive Committee and Board • An evaluation framework for each of the temporary changes has been approved	Reasonable	Updates provided to the Board
3.5	Work underway to develop the Route Map to Sustainability, linked to Better Together and achieving financial stability	Output from workshop sessions.	Reasonable	Updates provided to the Board
Mitigating Actions (What more will we do?)				

Action	Lead	Action update	Deadline	Action on Target
Continued implementation of the Value Based Health Care programme, including embedded value across the organisation focused on outcomes, experience and cost	EDFC&SS	This continues	Ongoing	On track
Secure access to and analyse PROMs and PREMs data for Powys patients to understand outcomes and experience	EDFC&SS	Collecting data. Identifying arrangements to analyse it	Ongoing	On track
Continued implementation of transformational programmes aligned to the PTHB Strategic Priorities to deliver agreed benefits and deliverables	DSI&T	This continues	Ongoing	On track
Implementation of Strategic Change deliverables to support achieving financial sustainability	DSI&T	In engagement phase of temporary changes.	Sep 2024	At risk, date to be reviewed
Current Risk Rating		**Update including impact of actions to date on current risk score**		
4 x 4 = 16		**4 x 4 = 16**		

CRR 009 **Risk that:** the care provided in some areas is compromised due to the health board's estate being not fit for purpose.	**Executive Lead:** Executive Director of Finance, Capital, and Support Services
	Assuring Committee: Delivery and Performance
Risk Impacts on: Organisational Priorities underpinning Well-being Objectives 1 to 4	**Date last reviewed:** January 2025
Risk Category: Quality	**Boards Risk Appetite:** Minimal

Risk Rating (likelihood x impact):

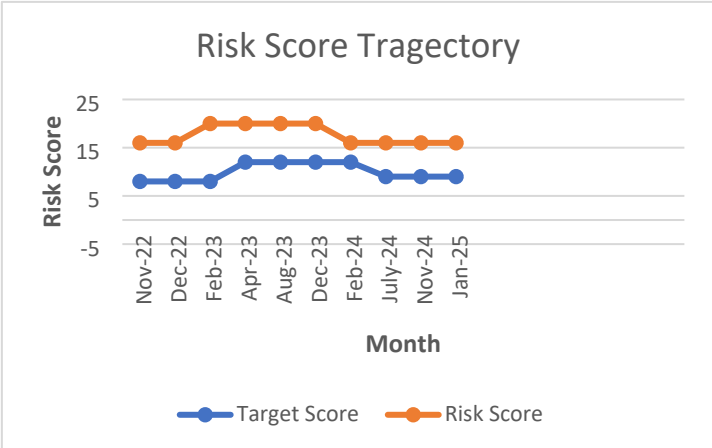
Inherent: 4 x 5 = 20

Current: 4 x 4 = 16

Target: 3 x 3 = 9

Date added to the risk register
January 2017

Source of risk:
Multiple risks arising from aging estate and levels of available funding to remedy.



Rationale for current score:

- **Estates Compliance**: 38% of the estate infrastructure was built pre-1948 and only 5% of the estate post-2005. Significant investment and risk-based programmes of work over several years across the compliance disciplines (fire, water hygiene, electric, medical gases, ventilation, etc.) will be required. Backlog Maintenance at circa £73M. Revenue position is also under significant pressure with energy costs and cost savings plan seeking reductions in expenditure on an aging and already under-invested estate (oldest in NHS Wales). Concerns raised by Internal Audit in March 2024 'Limited Assurance' report on Estates Condition identifying shortfall in funding required to address Backlog and support future Transformation.
- **Capital:** Financial constraints for NHS Wales has seen the introduction of a Capital Business Case Prioritisation Process which will test all current projects for benefits and affordability from April 2024 and this could impact the PTHB capital programme / transformation agenda. NWSSP-SSU audit in February 2024 identified a shortfall in WG Capital against backlog maintenance across the NHS estate with a Limited Assurance finding. Affordability concerns for larger contractors working in rural Powys with high overheads impacting scheme viability.

		▪ **Environment & Sustainability**: NHS Wales Decarbonisation Strategic Delivery Plan published in 2021 - challenging targets with limited resource.		
Controls (What are we currently doing about the risk?)		**Sources of Assurance**	**Level of Assurance**	**Highest Assurance provided to:**
	ESTATES			
9.1	Specialist sub-groups for each compliance discipline	Structured meetings, risk based approach, clear escalations lines	Reasonable	Estates Compliance Group
9.2	Risk-based improvement plans introduced	Highlight reports identifying and tracking risk mitigations, clear escalation lines	Reasonable	Estates Compliance Group
9.3	Specialist leads identified for key compliance areas	Authorised Persons independently appointed by NWSSP-SES	Reasonable	Estates Compliance Group
9.4	Estates Compliance Group and Capital Control Group established	Minutes, papers & work plans from meetings	Reasonable	Innovative Environments Group
9.5	Medical Gases Governance Group; Fire Safety Group; Water Safety Group; Electrical Safety Group; Asbestos Safety Group; Ventilation Safety Group convened with cross organisation & NWSSP-SES membership.	• Minutes and papers from meetings • Audits undertaken by NWSSP	Reasonable	Estates Compliance Group, Audit & Assurance Group
9.6	Capital Programme developed for Compliance and approved capital programme	Paper to Executive level meeting	Substantial	Delivery & Performance
9.7	Capital and Estates set as a specific organisational priority in the Health Board's Annual Plan	Annual Plan	Substantial	Board
9.8	Address (on an ongoing basis) maintenance and compliance issues	Compliance Highlight Reports, Audit plans, notes and papers from meetings	Reasonable	Delivery & Performance Group

9.9	Address maintenance and compliance improvements to ensure patient environment is safe, appropriate and in line with standards	Compliance Highlight Reports, Audit plans, notes and papers from meetings	Reasonable	Delivery & Performance Group
9.10	30+ Specialist Maintenance Contracts in place to ensure appropriate specialist service provision over 3-5 year contract periods	Contracts let via NWSSP-Procurement and contain Key Performance Indicator regime	Reasonable	Estates Compliance Group
	CAPITAL			
9.11	Capital Procedures for project activity	• Capital Procedures CP/D/1.00 document • Annual Capital Systems Audit reports from NWSSP	Reasonable	Innovative Environments Group
9.12	Routine oversight / meetings with NWSSP Procurement	• Notes from meetings • Annual Procurement Report	Substantial	Innovative Environments Group / Delivery & Performance
9.13	Specialist advice, support and audit from NWSSP Specialist Estates Services	• Notes from meetings • Designated Director role	Substantial	Innovative Environments Group
9.14	Audit reviews by NWSSP Audit and Assurance	Audit reports and Action Plans	Reasonable	Audit and Assurance Group
9.15	Close liaison with Welsh Government, Capital Function	Regular Capital Review Meetings. Notes and papers from meetings	Substantial	Innovative Environments Group
9.16	Reporting routinely to Delivery & Performance Committee	Notes and papers from meetings	Reasonable	Delivery & Performance Group
9.17	Capital Programme developed and approved	Paper to Executive level meeting	Substantial	Delivery & Performance Group / Board

9.18	Detailed Strategic, Outline and Full Business Cases defining risk	BJC, SOC, OBC, FBC documents / governance	Substantial	Executive Committee / Board
9.19	Capital and Estates set as a specific Organisational Priority	Annual Plan	Substantial	Board
9.20	Capital projects developed for consideration for Welsh Government slippage in order to take advantage of any available funding	Capital proposals sheets Project sheets SBARs	Substantial	Capital Control Group Innovative Environments Group
	ENVIRONMENT			
9.21	ISO 14001 accreditation	SGS external body certification	Substantial	Delivery & Performance
9.22	Environment & Sustainability Group	Notes and papers from meetings	Reasonable	Innovative Environmental Group
9.23	NWSSP-Specialist Estates Services (Environment) support and oversight	Meetings with Director NWSSP-SES	Reasonable	Innovative Environments Group
9.24	Welsh Government support and advice to identify and fund decarbonisation project initiatives	Presence on WG groups such as Community of Experts, etc.	Reasonable	Innovative Environments Group
9.25	Welsh Government Energy Service / Re:fit energy programme of works underway. Investment Grade Proposal (IGP) published to illustrate invest to save projects	Salix Framework arrangement	Substantial	Innovative Environments Group

Mitigating Actions (What more will we do?)				
Action	**Lead**	**Action update**	**Deadline**	**Action on Target**

Implement the in-year Capital Programme and develop the long-term capital programme which is responsive to changes in funding availability and funding sources.	Associate Director for Capital, Estates and Facilities	Fluid nature of NHS All Wales Capital allocations and current WG/NHS funding challenges make future capital investment uncertain. Outcome of All-Wales NHS Capital Prioritisation Review awaited but application for £30M made December 2024 to RPB IRCF for North Powys. Pressure on programme to divert capital to Transformation activity at short notice.	In line with Annual Plan for 2024-25	On Track
Continue to seek WG Capital pipeline programme funding continuity. Estates Funding Advisory Board (EFAB) for 2023/24 and 2024/25 secured. Phase 2 project Llandrindod with endorsed PBC and SBAR, with a total cost of £3.0M approved by WG. Further business case to be developed pending outcome of Capital Prioritisation Process. Machynlleth £15.2 reconfiguration of front of hospital completed March 2023 with Lessons Learned exercise completed with WG on 11 October 2024.	Associate Director for Capital, Estates and Facilities	PTHB secured £5 million of additional funding via the EFAB for 2023/24 and 2024/25 (Estates Funding Advisory Board) which is aimed to specifically address compliance and backlog maintenance issues across a range of technical specialist areas which may not normally attract business case submissions (Decarbonisation, Infrastructure, Fire, Mental Health). Reduction in NHS All Wales Capital allocations and current WG/NHS funding challenges make future capital investment uncertain.	In line with Annual Plan for 2024-25	On Track

		WG approval of £3M Phase 2 project Llandrindod Wells. Revised Discretionary Allocation 2025/26 will be £2.7m (from £1.431m). Targeted Estates Fund (TEF – replacing EFAB) NHS Wales total of £40m per year has been agreed for both 2025-26 and 2026-27 which is to be targeted at a range of activities; Infrastructure, Fire Safety, Mental Health, Decarbonisation, Infection Prevention Control and Decontamination with organisations required to support 30% out of discretionary capital.		
Develop capacity and efficiency of the Estates and Capital function	Associate Director for Capital, Estates and Facilities	Capital pipeline for investment by Welsh Government is now significant and capital team structure supported to ensure appropriate resource is available to support organisational ambition. Fluctuations in funding position have historically made core team resource commitment challenging – currently 30% vacancies and	In line with Annual Plan for 2024-25	On Track

		significant pressure on delivery.		
Review current structure of capital and estates department – Estates Management and Senior Management Team structure enhancements in place. Second tier of structure review required to address establishment staff numbers in Works Team and recruitment challenges. Resource review undertaken by IEG in 2023 with proposal limited by financial position.	Associate Director for Capital, Estates and Facilities	Due to financial challenges within the health board, this item is on hold.	TBC	At risk
Current Risk Rating		**Update including impact of actions to date on current risk score**		
4 x 4 = 16		**Estates:** Estates compliance – team continues to support core statutory compliance and limited Reactive job requests using risk-based approach due to age of estate. Workforce challenges for recruitment and staff resource establishment level being reviewed at Innovative Environments Group. Organisational recruitment freeze until FY end. **Fire:** Work to improve operational fire structure has been positive, but significant infrastructure risks related to compartmentation and physical systems remain. Programmes of work implemented but are dependent on capital funding. **Property:** significant pressure on space with expanding staff numbers alongside implementation of new agile working approach. Rationalisation of space of health board and other public sector bodies underway. International Recruitment has		

	introduced significant extra workload, which is affecting output of core activity. **Finance:** significant cost pressures related to energy and inflation are acting to increase pressure on Estates Revenue and Capital projects outturn costs and material / Supplier availability. Estates related pressure on revenue due to reactive failures of key building fabric and infrastructure.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 7.1

Delivery and Performance Committee	**06 February 2025**
Subject:	Joint Advisory Group on Gastrointestinal Endoscopy (JAG) Update – PTHB Endoscopy Service
Approved and Presented by:	Elaine Lorton, Executive Director Primary Community Care and Mental Health
Prepared by:	Assistant Director, Community Services Group Head of Planned Care
Other Committees and meetings considered at:	N/A

PURPOSE:

The purpose of this paper is to provide an update on the PTHB Endoscopy Service Joint Advisory Group (JAG) site reaccreditation assessment undertaken in March 2024 and progress against the resulting JAG actions.

This paper was also provided to the Planning, Partnerships and Population Health Committee (PPPH) on 4 February 2025, a verbal update will be provided

RECOMMENDATION(S):

The Committee is asked to:

- **NOTE** the update and that the paper will also be considered by the Planning, Partnerships and Population Health Committee (PPPH) on 4 February 2025.

Approve/Take Assurance	Discuss	Note
N	N	Y

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	Y	
2. Provide Early Help and Support	Y	
3. Tackle the Big Four	Y	
4. Enable Joined up Care	Y	
5. Develop Workforce Futures	Y	
6. Promote Innovative Environments	Y	
7. Put Digital First	Y	
8. Transforming in Partnership	Y	

EXECUTIVE SUMMARY

The purpose of this report is to provide an update on the PTHB Endoscopy Service JAG site reaccreditation assessment undertaken in March 2024 and progress against required JAG actions.

Progress is detailed against JAG advised improvement requirements; all actions other than in reach speciality medical leadership have been completed.

The JAG assessment process involves a significant amount of additional workload for the Planned Care Service Team and JAG were highly complementary of PTHB service, particularly the development of a management leadership triumvirate strengthening governance assurance, and the pride and passion demonstrated by all staff who clearly care about the standards.

DETAILED BACKGROUND AND ASSESSMENT

PTHB Endoscopy Service

The endoscopy service in Powys is provided by in reach consultants from Cwm Taf Morgannwg University Health Board (CTMUHB), PTHB clinical endoscopists (gastroscopy only) and PTHB supporting clinical and decontamination workforce. PTHB also delivers a bowel screening endoscopy from Brecon hospital within reach consultant from Hywel Dda University Health Board. Supplementary endoscopy capacity is also provided to the service via an insourcing provider currently Medinet. There is no dedicated endoscopy directorate in PTHB as would be found in other health boards the service is managed by a leadership triumvirate as part of a very broad portfolio of surgical and medical specialities.

Joint Advisory Group on Gastrointestinal Endoscopy (JAG)

JAG is a national body that reviews the performance of endoscopy services across the United Kingdom and helps to set and maintain national standards. JAG assessment involves an independent review of factors including patient feedback, staffing and quality of care, patient comfort, training building layout and environment, quality of equipment, cleaning standards, and the length of time patients wait between referral and diagnosis.

Services participating in JAG accreditation work to an accreditation pathway which involves self-assessment and quality improvement against the standards. Accredited services submit evidence annually to demonstrate that they are continuing to meet the standards and have a 5-yearly on-site assessment carried out by our experienced assessment team.

Of the 19 endoscopy sites in NHS Wales, only three are currently JAG accredited the others are all working toward accreditation.

PTHB JAG 5-year assessment – March 2024

Following the JAG 5-year assessment visit to the Powys Endoscopy Service in March 2024 the health board was advised that accreditation standards around speciality leadership had not been met and the award of accreditation was deferred. The assessment highlighted immediate actions regarding a gap in

speciality in reach medical leadership required to oversee speciality governance including the review of clinical performance indicators. JAG required the appointment of a new consultant speciality lead with endoscopy sessions in Powys and job planned time for speciality leadership role to include the review of clinical KPIs and on-going speciality support to clinical endoscopists.

The PTHB endoscopy service was highly commended for the following:

- the appointment of a new Senior Clinical (Nurse lead) and development of a management team triumvirate nursing/medical/general management strengthening governance assurance and leadership.
- the pride and passion demonstrated by all the team who clearly care about the standards of patient care and service user engagement.
- significant improvements in decontamination and collaborative working across departments with the health board.
- clear and appropriate operating procedures to support the booking scheduling of patients with the team congratulated on the hard work undertaken to reduce breaches and improve waiting times performance
- openness, honesty and clear desire to work hard and gain the standards required for JAG accreditation.
- clean, bright, well-maintained and organised facilities.

The service was required to provide evidence of adherence to the following actions within 6 months.

JAG Ref	Action Required	Progress	Action completed
1.1	Appointment of in reach consultant speciality lead to oversee governance and provide clinical support to endoscopists	Job description developed, shared with CTMUHB. On-going continuous engagement to secure speciality leadership operationally, via Commissioning Assurance Meetings and Exec to Exec discussions Colorectal surgery lead job description developed locum recruitment is in train awaiting final workforce checks. Overarch medical leadership in place Assistant Medical Director Planned Care. Clinical networking opportunities strengthened via Senior Nurse PTHB and Senior Nurse Endoscopy CTMUHB regular meeting in place.	
4.1,	Demonstrate clinical key performance indicators are reviewed, and actions taken to address any non-compliance	Clinical indicators have been reviewed by consultant colorectal surgeon/Assistant Medical Director Planned Care, findings shared via extraordinary meeting of PTHB Endoscopy User Group Nov 2024, CTMUHB in reach consultants and Medinet for insourced activity. No significant findings highlighted	√

		requirements for all consultants to increase number of images reported which will form part of audit cycle.	
1.5, 3.4, 3.4, 3.2,	Improved clinical audit schedule including nurse recorded pain scores, sedation, post colonoscopy colorectal cancer	Improved schedule in place with audits agreed with PTHB Corporate Audit Lead, operational Planned Care & Community Services Group Quality & Safety Groups, PTHB Endoscopy User Group. Incorporating development of audit for post colonoscopy colorectal cancer in collaboration with District General Hospitals.	√
4.3	Development of Standard Operating Procedure for managing underperforming endoscopists	Standard Operating Procedure developed in place agreed via PTHB Endoscopy User Group, Planned Care and Community Services Quality & Safety Meeting and Assistant Medical Director Planned Care/PTHB Medical Director.	√
12.1	Improve after care discharge leaflet	Discharge leaflets have been updated clarifying post procedural symptoms to look out for. Agreed via PTHB Endoscopy User Group, Planned Care and Community Services Quality & Safety Meetings.	√
9.3	Improve signage – toilets/staff areas	New signage is in place on both sites with toilets signposted from waiting areas and no entry signs for staff only areas	√
7.7	Provide single room capacity for "breaking bad news"	Re-design/organisation of endoscopy space to provide room capacity for breaking bad news requirement.	√
7.7	Improve patients experience re privacy and dignity	Redesign/Reorganisation of space/flow completed to improve patient experience.	√
11.4	Demonstrate capacity and demand modelling	Demand and capacity modelling in place as part of national modelling which is currently being reviewed nationally and locally to fit PTHB context. Service plan updated as part of key priorities plan for Planned Care/IMPT 25/26.	√

PTHB JAG Assessment Review Meeting – November 2024

A meeting was convened by a JAG Medical Assessor on 15th November 2024 to review PTHB progress against immediate actions in terms of speciality lead oversight. The Medical Assessor again commended the service on operational management, service transformation and strengthening of clinical/medical leadership and plans for additional colorectal surgery support. However formal confirmation regarding in reach speciality lead sessions (gastroenterology) was still pending and because of this outstanding issue accreditation was not

renewed. The PTHB service can still operate as normal (including the bowel screening service) without JAG accreditation as most units in NHS Wales currently do.

PTHB JAG Re-Accreditation – November 2025

Recognising the significant PTHB service progress to date, JAG have advised that the re accreditation process will be scheduled for November 2025. This re-process will be a bespoke assessment for PTHB covering only the outstanding action around speciality leadership as opposed to full-service review.

Governance Arrangements

JAG Assessment actions are managed at planned care service level through the Directorate Management Quality and Safety Meeting and Endoscopy Service Group which includes staff, user and in reach consultant representation.

Service monitoring and assurance update reports are provided to the Community Service Group Quality and Safety Group, with highlight reports to the relevant Board Committees.

NEXT STEPS:

The Planned Care service will continue to liaise with operational and commissioning teams for in reach servicesto ensure arrangements for speciality leadership are put in place in time for JAG reaccreditation later in 2025.

IMPACT ASSESSMENT – NOT REQUIRED FOR THIS REPORT

Core Financial Systems – Treasury Management

Final Internal Audit Report

November 2024

Powys Teaching Health Board

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

GIG CYMRU NHS WALES
Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Contents

Review reference:	PTHB-2425-15
Report status:	Final
Fieldwork commencement:	21st August 2024
Fieldwork completion:	8th October 2024
Debrief meeting:	24th October 2024
Draft report issued:	25th October 2024
Management response received:	15th November 2024
Final report issued:	19th November 2024
Auditors:	Ian Virgill, Head of Internal Audit, Warren Alexander, Principal Internal Auditor
Executive sign-off:	Pete Hopgood, Executive Director of Finance, Capital and Support Services
Distribution:	Hywell Pullen, Deputy Director of Finance Sarah Pritchard, Assistant Director of Finance (Accounting and Services)
Committee:	Audit Risk & Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Acknowledgement
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Executive Summary

Purpose

The overall objective of the audit is to evaluate and determine the adequacy of the systems and controls in place within the Health Board for Treasury Management.

Overview

We have issued substantial assurance on this area.

The matters requiring management attention include:

- The need to ensure that Financial Control Procedures are subject to regular review and updating.
- Bank mandates need to be reviewed to ensure that signatories are up to date and appropriate financial limits are stipulated.

Other recommendations / advisory points are within the detail of the report.

Report Opinion

		Trend
Substantial 	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.	N/A

Assurance summary[1]

Objectives		Assurance
1	Financial Control Procedure	Reasonable
2	Cash Forecast Production	Substantial
3	Cash Forecast Updates	Substantial
4	Receipts and Payments	Substantial
5	Transfers	Reasonable
6	Bank Account Reconciliations	Substantial

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Financial Control Procedure Reviews	1	Operation	Medium
2	Bank Mandates / Account Access	5	Operation	Medium

1. Introduction

1.1 A review of Core Financial Systems was completed in line with the Powys Teaching Health Board's (the 'Health Board' or 'PTHB') 2024/25 Internal Audit Plan.

1.2 As part of the 2024/25 Internal Audit planning process, it was agreed that the core elements of the Health Board's financial systems would be subject to review on a cyclical basis. The first area to be reviewed is Treasury Management.

1.3 Treasury Management is concerned with the process of managing all cash transactions relating to the funding of revenue and capital operations of the Health Board. There must be effective processes and procedures in place to ensure that all of the Health Board's financial obligations (e.g. the payment of employees and suppliers) can be met without interruption.

1.4 Treasury Management includes cash forecasting, cash flow management, receipting and banking controls.

1.5 The Executive Director of Finance, Capital and Support Services is the lead Executive for this audit.

2. Detailed Audit Findings

Objective 1: Arrangements for Treasury management are documented within an up-to-date financial control procedure.

2.1 PTHB Standing Financial Instructions are available on the PTHB Internet site. The current version specifies a publication date of September 2021 (updated September 2023) but does not specify a future review date. **(Matter Arising 1).**

2.2 Comprehensive Financial Control Procedures (FCPs) are in place which provide guidance to staff performing duties in relation to the Health Board's finances. Several of these FCPs are of particular relevance to the Treasury Management functions. For the purposes of this audit, detailed reference has been made to:

-FCP 005 (Commercial Bank Accounts Control)

-FCP 017 (Cash Forecasting and Management)

2.3 A sample of specifications detailed in selected Financial Control Procedures was selected and cross-checked with relevant sections of the Standing Financial Instructions to ensure no contradictory guidance had been included.

2.4 Section 7 of the SFIs (Banking Arrangements) were checked against the recently revised FCP 005 and it was found that the controls specified in the FCP supported the requirements of the SFI.

2.5 Section 7.2 of the SFIs lists responsibilities of the Director of Finance in relation to the maintenance of the Health Board's bank accounts. The FCP supports this by specifying that the authorisation of the Director of Finance must be sought in relation to the setting up of accounts, and by setting out reporting requirements.

2.6 Section 7.3 states that the Director of Finance will prepare detailed instructions on the operation of bank accounts, that ensure there are sound controls over the day-

to-day operation of bank accounts and lists eight expected controls. All were found to be addressed in the relevant sections of the FCPs.

2.7 The specifications detailed in FCP 017 address the requirements of the SFIs with respect to cash forecasting procedures. The financial reporting framework prescribed by the Welsh Government (WG) also requires that forecasting procedures are followed. It is likely that any significant deficiencies in this area would result in one or more of the following adverse outcomes:

- An account belonging to the Health Board may become overdrawn;
- The balance of a Health Board account may be insufficient to service payments which become due;
- Interim 'top-up' payments would be required more frequently, or could not be adequately justified, which would likely result in queries from the WG; and
- The balance of a Health Board account remaining at the end of a payment period is unnecessarily high, or a balance accrues incrementally and is not reduced.

2.8 Therefore, whilst procedures in relation to cash forecasting are documented in FCP 017, there are also additional controls relating to the submission of financial information to WG which ensure that accuracy and consistency of reporting is maintained.

2.9 The PTHB Scheme of Delegation document was adopted by the Health Board in July 2021, and was amended in May 2022, May 2023 and September 2023.

2.10 The Scheme of Delegation is principally comprised of a table which lists the requirements of the SFIs and the delegation arrangements which relate to them. This provides some assurance that the contents of the Scheme of Delegation are concordant with the SFIs.

2.11 Oracle requisition limits are specified in the Scheme of Delegation and are as follows:

- Up to £10k - Nominated Budget Holder for Specific Cost Centres
- £1k to £25k - Assistant Directors
- Up to £50k - Executive Directors
- Up to £100k – Chief Executive

2.12 It is unclear why a lower threshold is specified for Assistant Directors only.

2.13 Limits are also specified for expenditure commitments made outside of the Oracle requisition process. These relate to expenditure categories such as pharmacy drugs, pension agency invoices and legal claims. Limits and delegation arrangements were found to be appropriate.

2.14 SFI requirement 9C specifies arrangements for the establishment of bank accounts and that related responsibilities are delegated to the Head of Financial Services. (**Matter Arising 2)**.

2.15 The Financial Control Procedures examined during this audit were in the process of being reviewed. Updated copies that had not been approved at the time of audit were provided for FCP 001 and FCP 005.

2.16 Copies of eight out of a total of ten FCP documents currently published on the PTHB intranet site specify an Issue date of September 2015 and a scheduled Review date of September 2018. FCP 010 was issued in March 2017 with a review date specified as March 2020. **(Matter Arising 3).**

2.17 FCP 007 was issued in March 2024 and is not due for review until March 2027. FCP 021 was issued in September 2021 and is imminently due for review (September 2024).

2.18 During our enquiries in relation to the FCPs we were informed that in general, very few changes occur which relate to the FCPs and as such, updates are made infrequently.

Conclusion:

2.19 Standing Financial Instructions are in place and up to date. Some updates are outstanding with respect to the Financial Procedure Rules and review dates have not been defined. This objective has been given a **Reasonable** assurance rating.

Objective 2: A full year cash forecast is produced in a format consistent with the financial Monitoring returns.

2.20 A cashflow forecast covering the current financial year comprises part of the Monthly Monitoring Return Submissions to WG, and as such is updated on a monthly basis.

2.21 A total of twelve bank accounts belonging to the Health Board were examined during the course of the audit. Statements for each account covering a four-month period from April to July 2024 were reviewed, and all accounts were in credit at all times.

2.22 General guidance in relation to the submission of the Health Board's Monthly Cash Forecast to WG is contained within FCP 017, which is available on the PTHB intranet site. More specific operational guidance has not been produced. **(Matter Arising 4)**.

2.23 A 'Welsh Health Circular' containing monthly financial monitoring return guidance and associated submission templates was issued on 20th May 2024. This contains detailed specifications with respect to the financial reporting requirements imposed upon Health Boards by WG.

2.24 Monthly cash requests are made by the Health Board to WG using a standard 'Financial Information System' (FIS) spreadsheet. These are required to be submitted 5 working days prior to the end of every month, and contain information with respect to the Health Board's projected income and expenditure over the following month.

2.25 Regular monthly submissions for April, May, June and July 2024 were examined, all had been submitted to WG in accordance with prescribed deadlines.

2.26 Monthly Monitoring Returns for April, May, June and July 2024 were also examined and all were submitted in accordance with WG deadlines.

Conclusion:

2.27 Full year cashflow forecasts are produced in a format mandated by the Welsh Government. Monthly cash requests and Monitoring Returns are submitted to WG in a timely manner. This objective has been given a **Substantial** assurance rating.

Objective 3: Regular updates to the cash forecast are made and reviewed, with significant changes being appropriately reported.

2.28 The cash flow forecast is updated as information becomes available or monthly during the production of the Monthly Monitoring Returns for WG.

2.29 Expenditure is monitored by a designated Financial Accountant who uses information from prior periods, creditor balances and other relevant sources of information such as pay award announcements to ensure expenditure forecasts are as accurate as possible.

Conclusion:

2.30 Cashflow forecasts are updated with appropriate frequency and information from relevant sources is incorporated, therefore, this objective has been given a **Substantial** assurance rating.

Objective 4: Receipts and payments are accurately recorded, and Cash balances are regularly reviewed to ensure that there are sufficient funds against forecasts with cash allocation requests appropriately requested and authorised.

2.31 The cash flow forecasts are prepared in an established format. Accordingly, there are sections that must be completed which relate to receipts and payments.

2.32 A potential shortfall was identified in April 2024. A higher level of creditor payments than anticipated resulted in the Health Board requesting an additional £3m of funds to be credited on 26th April.

2.33 This request was made to the Welsh Government by e-mail on 12th April, and there is evidence to demonstrate that the Assistant Director of Finance (Accounting and Services) was notified. This measure was shown to be necessary, as the balance of the Health Board's main bank account was approximately £220k when the following scheduled monthly deposit was received.

Conclusion:

2.34 Receipts and payments were found to be accurately recorded, cash balances are regularly reviewed, and cash allocation requests are appropriately requested and authorised. This objective has been given a **Substantial** assurance rating.

Objective 5: Transfers between accounts are appropriately authorised.

2.35 Bank mandate change requests were obtained in relation to the Health Board's main Government Banking Service (GBS) account, two Barclays accounts, and eight of the nine Subsidiary Bank Accounts (SBA) belonging to the Health Board's hospitals. Authorised individuals were checked against the NHS Wales directory to verify that they were still live users and that no significant changes to their role had been recorded.

2.36 Mandates in relation to the two PTHB Barclays accounts were up to date and appropriate individuals were specified.

2.37 With respect to the nine SBAs examined, mandates in relation to two of them authorised individuals who no longer appear to work for PTHB. **(Matter Arising 5)**.

2.38 All SBA mandates specified that only one authorised individual was required in order to authorise payments, and authorised limits were noted on only four mandates. The terms detailed in the standard mandate form would appear to indicate that where authorised signatories are not subject to any financial limits, they are by default invested with wide-ranging authority, including the ability to open and close accounts, apply for banking products, enter into agreements and receive information about any account held with the bank. Seven of the mandates examined did not specify financial limits and it would therefore appear that the individuals listed have been granted this authority.

2.39 Whilst it is recognised that the SBAs are credited only with very limited funds, thereby providing control over the payments made by the authorised signatories, the additional authorities granted to signatories to whom no financial limits are applied do not appear to be commensurate with the roles of the specified individuals or otherwise necessary for the performance of their duties. **(Matter Arising 5)**.

2.40 The bank mandates examined contained details of seven instances whereby authorisations were removed from individuals. One of these instances related to the PTHB Barclays accounts, and six related to various subsidiary accounts. All were correctly authorised.

2.41 Account access arrangements relating to the main Government Banking Service account were checked, and it was verified that access rights have been appropriately delegated to senior members of the PTHB Finance team. One individual who no longer works in the Team was listed as having current 'authorisation' and 'view' permissions. **(Matter Arising 5)**.

2.42 Three individuals were listed as being able to both input and approve payments, but it was confirmed that the software does not allow an individual to approve a payment that they have input.

2.43 Payment authorisation limits were specified on mandate change requests in relation to four of the nine subsidiary accounts. There was e-mail correspondence to indicate that a £250k dual authorisation limit was also applicable to the Health Board's GBS account.

2.44 Three transfers from the PTHB Barclays Main Account to different subsidiary accounts were examined. All transfers related to petty cash claims and each case was supported by detailed documentation that had been appropriately authorised by the requestor and the PTHB Finance Department.

2.45 Unreconciled items in respect of the main PTHB accounts largely consisted of transactions which occurred after the monthly closedown deadline and unpresented cheques. No areas of concern were identified.

2.46 It was noted that payments from the SBAs were not always reported promptly, with some remaining outstanding for in excess of 4 months. It is understood that the SBAs are administered much in the same manner as petty cash accounts, in that they are used only for incidental expenditure and funds are replenished as required. (**Matter Arising 6)**.

Conclusion:

2.47 All transactions examined were appropriately authorised. Some minor control deficiencies were identified in respect of SBAs. This objective has been given a **Reasonable** assurance rating.

Objective 6: Bank account reconciliations are appropriately completed.

2.48 Reconciliations of all Health board Bank Accounts are undertaken on a monthly basis. Reconciliations covering a four-month period from April to July 2024 were examined in relation to 12 of the Health Board's Bank Accounts, these included the main Government Banking Service Account, two Barclays accounts, and 9 SBAs belonging to the Health Board's hospitals.

2.49 Reconciliations are completed by the Finance Assistant, authorised by the Financial Accountant, and queries or irregularities may be escalated to the Assistant Director where appropriate.

2.50 All of the 48 reconciliations examined (12 accounts over 4 months) had been completed and verified appropriately. Values were checked against bank balances and financial ledgers and all agreed.

2.51 The combined balances of the SBAs at the end of the period examined (31st July 2024) was £9259.59, the average balance was therefore approximately £1k, and the maximum balance was £2,028 (Bronllys SBA, April 2024).

2.52 The Health Board's main GBS bank account was reviewed to ensure expected receipts relating to the monthly FIS form submissions of April, May, June and July 2024, in addition to the supplementary FIS of April 2024 were received. All values matched with the corresponding payment request.

2.53 A total of fourteen transactions across the Health Board's principal three bank accounts were selected and checked to source documentation.

2.54 Three transfers comprised part of the selection, which are detailed in 2.44.

2.55 Eleven further payments of various types were checked. All had been appropriately authorised and were supported by documentation.

2.56 The schedule of unpresented cheques is updated as part of the monthly bank reconciliation process. As of July 2024, a total of £3,537.89 in unpresented cheques were listed for the Barclays payments account. Cheque payments are also made from subsidiary accounts, and the values of unpresented cheques were also included in the reconciliation process.

Conclusion:

2.57 Bank account reconciliations were completed appropriately, suitably verified and adequately documented. This objective has been given a **Substantial** assurance rating.

Appendix A: Management Action Plan

Matter Arising 1: Standing Financial Instruction Reviews (Operation)			**Impact**
Whilst it has been noted that the current Standing Financial Instructions were published relatively recently (September 2021), and updated at an appropriate interval (September 2023), a schedule of future reviews is not specified in the document.			Potential risk of: • Adequate procedural guidance is not available to staff.
Recommendations			**Priority**
1.1	A schedule of future reviews or details of established review intervals should be included in the Standing Financial Instructions.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
1.1	Agreed - The SFIs are mainly standard documents provided to the THB by Welsh Government with some minor amendments for local circumstances. The THB will put a note on the document to state that the SFIs will be internally reviewed every 2 years should a review by Welsh Government not be undertaken during that period.	31 December 2024	Helen Bushell, Director of Corporate Governance

Matter Arising 2: Outdated References (Operation)			**Impact**
Reference is made in the Standing Financial Instructions to the Head of Financial Services. Executive changes within the Health Board have resulted in this role being superseded by the Assistant Director of Finance (Accounting and Services).			Potential risk of: • Adequate procedural guidance is not available to staff.
Recommendations			**Priority**
2.1	The Standing Financial Instructions should be updated to ensure references to the Head of Financial Services are updated to the Assistant Director of Finance (Accounting and Services).		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
2.1	Agreed - The change to title will be made at next update of Scheme of Delegation scheduled for late 2024.	31 January 2025	Helen Bushell, Board Secretary/ Sarah Pritchard, Assistant Director of Finance (Accounting and Services)

Matter Arising 3: Financial Control Procedure Reviews (Operation)			**Impact**
Ten FCPs with varying degrees of relevance to treasury management were examined as part of this review, and review dates in relation to eight of them had elapsed. Seven of the FCPs had review dates of September 2018. Reviews are currently being undertaken and copies of two updated FCPs were pending approval.			Potential risk of: • Procedural guidance is out of date.
Recommendations			**Priority**
3.1	Efforts should continue to ensure all FCPs with elapsed review dates are subject to an appropriate review process and submitted for the relevant approvals. Future review dates should then be defined, or an established review frequency should be determined and specified within each document.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
3.1	Agreed - There is currently LHB review of policy process underway which is due to conclude during 24/25. All FCPs will be reviewed and where required approval undertaken and where required review frequency included within the document.	31 March 2025	Sarah Pritchard, Assistant Director of Finance (Accounting and Services)

Matter Arising 4: Operational Guidance (Design)			**Impact**
Limited procedural guidance is available to staff in relation to the cash flow forecasting process. In the context of there being a limited number of individuals involved to any significant degree in the process, this presents risks in terms of business continuity.			Potential risk of: • Adequate procedural guidance is not available to staff. • Welsh Government sanctions.
Recommendations			**Priority**
4.1	Detailed guidance should be produced in order to document the procedures utilised in the cash flow forecasting process.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
4.1	Actioned since Audit Fieldwork – Detailed guidance on the cash flow forecasting process has been produced.	Complete	Ian Jackson, Financial Accountant

Matter Arising 5: Bank Mandates / Account Access (Operation)	**Impact**
One case of GBS account access permissions, and two bank mandate change requests authorised individuals who no longer appear to be employed by PTHB. No clear review process appears to be in place to provide assurances that account access permissions and bank mandates are up to date. SFI 7.3.1 c) specifies effective divisions of duty for employees working within the banking and treasury management function to minimise the risk of fraud and error. All authorised signatories of subsidiary bank accounts listed in the mandates examined have been authorised to make payments on their sole authority. Seven mandate updates appear to grant general authority to the nominated signatories, and specifically refers to the ability to open and close accounts. This introduces a risk that FCP005, which specifies 'Any arrangement to set up a bank account relating to PTHB business must be approved by the Director of Finance', is contravened. It is recognised that the SBA accounts are credited only with very limited funds, thereby providing a level of control over the payments made by the authorised signatories and reducing the associated level of risk.	Potential risk of: • Account access permissions and bank mandates should be updated to ensure any authorised users/signatories who no longer require authority are removed.

Recommendations		**Priority**
5.1	Account access permissions and bank mandates should be updated to ensure any authorised users/signatories who no longer require authority are removed.	**Medium**
5.2	Financial limits should be implemented in respect of all authorised signatories of subsidiary bank accounts. In cases where higher limits are determined to be necessary, consideration should be given to adding a stipulation requiring two signatories to authorise payments which exceed a predefined threshold.	
5.3	A list of authorised signatories should be maintained and subject to periodic review.	

Agreed Management Action		Target Date	Responsible Officer
5.1	Agreed - The finance department are reliant on local administration teams advising of changes required. A full review will be undertaken and signatories updated to reflect current signatories only where required.	31 March 2025	Ian Jackson, Financial Accountant
5.2	Agreed - Officers will work with the bank to ensure the documentation is updated for all accounts to define a limit where this is currently omitted.	31 March 2025	Ian Jackson, Financial Accountant
5.3	Agreed - A list of mandate signatories will be defined and subject to regular review	31 March 2025	Ian Jackson, Financial Accountant

Matter Arising 6: Subsidiary Account Transactions (Design)			**Impact**
Unreconciled items in the Health Board's main bank accounts were minimal, with the exception of some transactions which occurred subsequent to the monthly closedowns, and unpresented cheques. Details relating to payments from the subsidiary bank accounts were reported irregularly, and some transactions remained unreported for extended periods of time.			Potential risk of: • Unauthorised or fraudulent payments are made.
Recommendations			**Priority**
6.1	Subsidiary Bank Account Administrators should be instructed to report upon transactions within three months of the original transaction date.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
6.1	Actioned since Audit Fieldwork – relevant staff members have been emailed to request that all Subsidiary Bank Account returns are undertaken more frequently and as a maximum within a 3-month period.	Complete	Sarah Pritchard, Assistant Director of Finance (Accounting and Services)

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**Unsatisfactory assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

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Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

Board & Committee Structure/Effectiveness

Final Internal Audit Report

2024/25

Powys Teaching Health Board

Substantial Assurance

Contents

Review Reference	PTH-2425-02
Fieldwork	September - November 2024
Executive Sign Off	03 December 2024
Audit Committee	January 2025
Executive Lead	Helen Bushell, Director of Corporate Governance/Board Secretary
Audit Team	Ian Virgill, Head of Internal Audit Lucy Jugessur, Deputy Head of Internal Audit

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Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

To evaluate Powys Teaching Health Board's (the 'Health Board') Board and Committee structure and assess the operation of the Board and Committees to ensure effective and efficient reporting, scrutiny and decision making on areas of accountability.

Overview

The current committee structure of the Health Board has been in place since August 2021 with the following committees currently in operation:

- Audit, Risk and Assurance Committee.
- Charitable Funds Committee.
- Delivery and Performance Committee.
- Executive Committee.
- Patient, Experience, Quality & Safety Committee.
- Planning, Partnerships and Population Health Committee.
- Remuneration and Terms of Service Committee; and
- Workforce and Culture Committee.

This review follows on from the previous audit of Board & Committee Structure/ Effectiveness which we completed in 2023/24, and covers the workings of the Board; Audit, Risk and Assurance Committee; Planning, Partnerships and Population Health Committee; and Workforce and Culture Committee.

We have concluded **Substantial** assurance on this area. We have identified no key matters for reporting in our review.

Opportunities for Enhancement

The following opportunities for enhancement have been identified that do not impact the overall opinion and are highlighted for management information:

- Consideration should be given to discussing with Welsh Government the potential of ongoing training and awareness exercises for Independent Members post-appointment, outside that already provided by the Health Board.

Scope & Assurance Summary

	Objectives	Related Findings	Assurance
1	The Health Board has clear, defined Board and Committee governance and assurance structures.	-	**Substantial**
2	The Committee structure provides for clear, effective and efficient decision-making and scrutiny on areas of accountability.	-	**Substantial**
3	Board and Committee work programmes are aligned to the Health Board's strategic objectives and risks.	-	**Substantial**
4	Board and Committee reporting is clear and concise and provides effective triangulation of business activity.	-	**Substantial**

Findings & Agreed Action Plan

Objective 1: The Health Board has clear, defined Board and Committee governance and assurance structures.	**Substantial**

Overview / Summary of Observations

The Health Board has current Standing Financial Instructions and Standing Orders in place that outline and formalise the Board and Committee governance structures and arrangements, and these were recently reviewed and updated, and approved by the Board in May 2024.

The Board's Terms of Reference (ToR) forms part of the Health Board's Standing Orders and is current in its constitution. All three sampled Committees (Audit, Risk and Assurance Committee; Planning, Partnerships and Population Health Committee; and Workforce and Culture Committee) ToR are also current in content having been reviewed and updated and approved by the Board in May 2024.

Additionally, each ToR states the constituent membership, roles and responsibilities of the Committee; and their reporting arrangements, membership quoracy and frequency of meetings to be held.

Our review of Committee meeting structures, and of their respective areas of responsibility as stated within the Standing Orders and Committee ToR documents, confirmed that they were appropriate and did not identify any potential overlap or conflict of subject matter between Committees.

Independent Member Induction and ongoing training/development

The Health Board has an induction process for new members, and provides ongoing support, training and development that enables Independent Members to effectively undertake their roles and management of their respective Committees.

Our discussions with the Committee Chairs of the three sampled Committees identified their satisfaction with the Health Board's induction process, and the regular and ongoing provision of training, development and guidance available to them, and also the support provided by the Corporate Governance Team.

However, we identified that upon completion of the Welsh Government induction process undertaken by Independent Members upon appointment, no further training/awareness is provided to them by Welsh Government. As such, the Health Board should consider discussing with Welsh Government, the possibility of introducing ongoing Independent Member training, outside that already provided by the Health Board, to further enrich their roles within NHS Wales Health Bodies.

Objective 2: The Committee structure provides for clear, effective and efficient decision-making and scrutiny on areas of accountability.	**Substantial**

Overview / Summary of Observations

As part of our review, we attended meetings of the Board; Audit, Risk and Assurance Committee; Planning, Partnerships and Population Health Committee; and Workforce and Culture Committee. We also met with the Board Chair and Chairs of the aforementioned Committees to discuss their views and approach toward effective Committee management and proceedings

As such, we can confirm that the Health Board Chair and the sampled Committee Chairs effectively manage their meetings and engage with their membership to allow appropriate scrutiny, dialogue, and debate of Agenda items in an efficient manner, in accordance with their prescribed roles and respective experience that they bring to the Health Board.

Additionally, our review of the minutes from a sample of Board and Committee meetings undertaken during 2024/25 demonstrated the scrutiny undertaken, decisions made, and the follow up and confirmation of action completion as appropriate in subsequent Committee Action Plans. This process is supported by an action/issues log tracker spreadsheet for Board and all Committees meetings, and this is accurately maintained by the Corporate Governance Department.

<u>Declarations of Interests</u>

The Corporate Governance Department has a process in place to monitor and manage the annual return of Declarations of Interests, and our testing confirmed that all Board Members and the Executive Team had completed and submitted a Declaration of Interest form for 2024/25.

The Board and Committee Chairs also confirm if there are any specific declarations of interest to be made at the start of each meeting, relating to items included within the individual agendas. Any declarations highlighted through this process would be effectively managed within the meeting to ensure no conflict of interest arises.

Objective 3: Board and Committee work programmes are aligned to the Health Board's strategic objectives and risks.	**Substantial**

Overview / Summary of Observations

Current Work Programmes are in place for 2024/25 to ensure that the Board and its Committee's annual activity is effectively timetabled, and covers all required areas, as detailed within the Health Board's Standing Orders and the respective TOR.

Our review of the Work Programmes for the Board and the three sampled committees also confirmed that they are aligned to, and provide effective coverage of, the Health Board's strategic objectives and key risks.

Where applicable, deferment or removal of Agenda items are recorded accordingly within the respective Work Programmes.

Our testing of the minutes from a sample of Audit, Risk and Assurance Committee; Planning, Partnerships and Population Health Committee; and Workforce and Culture Committee meetings held during 2024/25 confirmed that all items stated on their Work Programmes were undertaken as timetabled.

Objective 4: Board and Committee reporting is clear and concise and provides effective triangulation of business activity.	**Substantial**

Overview / Summary of Observations

Our testing of the sample of Board; Audit, Risk and Assurance Committee; Planning, Partnerships and Population Health Committee; and Workforce and Culture Committee meetings held during 2024/25 confirms that the minutes are accurately documented, and their actions and decisions are clearly delivered. The papers are made available for Board and Committee Chairs and their constituent membership in a timely manner prior to commencement of each meeting.

We also confirm that the agendas, minutes and other papers for these Board and Committee meetings were made available to Health Board staff, the general public and stakeholders for scrutiny, by being published on the Health Board's website in advance of each meeting held.

Our review of the aforementioned Committee meeting cover papers and reports confirm that they are of a high quality, and are detailed and thorough in content, and our conversations with Committee Chairs confirmed their satisfaction in this regard.

Furthermore, our testing also confirmed the submission of each Committee Chair's Update Report to subsequent Board meetings, evidencing the reporting of their key Agenda items and outcomes/actions to be undertaken.

Appendix A

Assurance Opinion

 **Substantial**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
 **Reasonable**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
 **Limited**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
 **Unsatisfactory**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
 **Advisory**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

Disclaimer

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Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Teaching Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management of the Teaching Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Public Sector Internal Audit Standards

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Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership]

Capital Systems

Final Internal Audit Report

2024/25

Powys Teaching Health Board

Reasonable Assurance

Contents

Review Reference	PTHB-SSU-2425-26
Fieldwork	July - September 2024
Executive Sign Off	19 November 2024
Audit Committee	9 January 2025
Executive Lead	Pete Hopgood
Head of Internal Audit	Huw Richards
Deputy Head of Internal Audit	Eifion Jones

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Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

This audit was commissioned in accordance with the agreed 2024/25 Internal Audit Plan. Capital systems coverage during 2024/25 focussed on the selection, appointment and contractual arrangements applied at Capital and Estates projects (covering both advisers and contractors).

Overview

Over the past few years, Capital and Estates have dedicated substantial time and effort to developing a structured control environment for their projects. This commitment has involved implementing a capital toolkit designed to enhance project management and oversight. By establishing clear processes and standards, the department has aimed to ensure consistency and quality across all projects. Whilst good compliance was noted in most areas, there were some matters that required further management attention e.g.:

- Developing appropriate contract strategies to ensure consistency in the contracts utilised and executed.
- Reviewing the capital procedures to ensure document retention criteria associated with construction contracts is appropriately defined.
- Standardising the level of detail in the procurement strategy for individual projects.
- Establishing mechanisms to track and monitor areas for improvement identified within the annual procurement reports.

Full detail of these matters is provided within the Findings & Agreed Action Plan. Additionally, the following opportunities for enhancement have been identified, which do not impact the overall opinion but are highlighted for management information:

- Horizon scanning for changes to procurement rules due to take effect from February 2025 and assessing how these may affect current operational processes.
- Exploring opportunities for training related to the upcoming changes to procurement rules.

We have concluded **reasonable assurance** in this area.

Scope & Assurance Summary

	Objectives	Related Findings	Assurance
1	Governance - To assess the application of appropriate procurement policies and procedures to Capital and Estates contracts and ensure that roles and responsibilities and approval requirements were adequately defined.	-	**Substantial**
2	Contract Completion – To obtain assurance on the timely completion, recording, and approval of agreement/ contract versions in accordance with the approved contract strategy (with appropriate inclusions and clauses).	1	**Limited**
3	Selection and Appointment – To ensure the appropriate application of Standing Orders, Standing Financial Instructions (SFIs), national and local procurement policies for the selection and appointment of contractors and technical advisers. To ensure the application of appropriate competitive	2,3	**Reasonable**

	tender/quotation arrangements, the use of frameworks (as applicable) and the appropriateness of associated management and reporting.		
4	Value for Money and Award – To ensure that there was an appropriate assessment of value for money (e.g. via tendering/ quotation, benchmarking etc), with formal recommendations for award. Appropriate approvals were in place, that fully considered the above and any associated limitations.	1,2	**Reasonable**
5	Retention of contract and project documentation - To obtain assurance that Capital and Estate's contract information was retained for the requisite period (in accordance with national guidance) and that all contract documentation was held securely.	4	**Reasonable**

Management Actions

1
High Priority

3
Medium Priority

Themes

Risk Types

Legal & Regulatory Non-Compliance

Public Perception & Reputational Risk

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Capital Systems - At a Glance

Purpose

A total of 10 projects were sampled for this audit covering a range of financial years, values and funding sources as follows:

Project title	Financial Year	Project Total Cost (£)	Funding Mechanism
Courtyard Refurbishment, Bronllys Hospital	2023/24	65,000	Discretionary
Park Offices Enabling Works	2023/24	135,000	Discretionary
Refurb of Podiatry – Welshpool Hospital	2023/24	35,000	Discretionary
Bungalow 3 Refurbishment Bronllys Hospital	2024/25	35,000	Discretionary
Llanidloes Hospital, Staff Room	2024/25	45,000	Discretionary
Electrical Substation Capacity Upgrade, Welshpool Hospital	2023/24	372,600	Estates Funding Advisory Board
Waste Compliance	2023/24	12,060	Estates Funding Advisory Board
Ystrad Solar PV	2024/25	300,000	Estates Funding Advisory Board
Bronllys Hospital, Roofing	2023/24	1.480,000	All Wales Capital Programme
Bronllys Hospital, Car Park	2024/25	250,000	All Wales Capital Programme

Findings & Agreed Action Plan

Objective 1: Governance Arrangements	**Substantial**

The Teaching Health Board (THB) adopted the NHS Model Standing Orders, Reservation, and Delegation of Powers in July 2021, with the latest amendments made in September 2023. The Scheme of Delegation – Standing Orders Schedule detailed requirements for approval of capital schemes funded through discretionary allocations. The THB's Capital Procedures, approved by the Innovative Environment Group in September 2023, outlined clear ownership and accountability requirements. Updates to the Capital Procedures Reviews were linked to lessons from previous audits and post-project review documentation. This was seen as a positive practice.

The THB also used a capital booklet to provide guidance and ensure a standardised approach to project management. This booklet includes various forms and documents to be completed throughout the project lifecycle, broken down into stages for ease of completion. Additionally, the Capital and Estates department maintained an annual declaration of interests, which were logged centrally and categorised by roles, including the Capital Team, Estates Team, and admin teams. This structured approach helped maintain transparency and accountability within the department.

Objective 2: Contract Completion	**Limited**

The THB's SFIs section 11 set out the procurement thresholds for capital projects, including the form of contract to be adopted. The THB's Capital Procedures reference the need to comply with the SFIs, however there was no detailed contract strategy as to how this was to be implemented at an operational level. This led to an inconsistency in approach at the induvial projects sampled, whereby four projects had no contract in place.

By ensuring that a comprehensive and tailored contract strategy is in place, management will better position the THB to deliver successful outcomes across its programmes and services, while maintaining accountability, financial control, and quality assurance.

Where contracts were in place, they were appropriately signed and included key clauses such as:

- Rectification periods.
- Sectional completion.
- Liquidated ascertained damages.

These clauses were essential for maintaining project integrity and ensuring liabilities were well-understood.

Key Findings		Risk & Impact	Agreed Management Action
1	**Contract Strategy** SFIs section 11 outlines:	Lack of adequate legal protection and accountability, which can lead to disputes, cost overruns, project	A 'contract strategy' form to be added to the Capital Procedures booklet to capture decisions and justification for chosen form of contract for each applicable project. The updated capital procedures were signed off at Innovative Environments Group on 8 November 2024.

Goods/Services/Works Whole Life Cost Contract value (excl. VAT)	Form of Contract
<£5,000	Purchase Order
>£5,000 - <£25,000	Simple Form of Contract/Purchase Order
>£25,000 – Prevailing OJEU threshold	Formal contract and Purchase Order
>OJEU threshold	Formal contract and Purchase Order

Capital Procedures section 4 reference the need to comply with the above table. However, there was no detail as to how this would be implemented.

The audit sampled 10 projects above £5000, purchase orders were in place for all projects sampled. However, there was an absence of formal contract documentation at 4 projects. For example, at the Bronllys Courtyard Refurbishment £78,034, the Joint Contracts Tribunal (JCT) minor works contracts were intended to be used; however, no contract was implemented - no explanation or justification for this variation was documented.

Where contracts had been utilised, there were also variations within the contract types e.g. JCT versus New Engineering Contracts (NEC) for contractors.

delays, and quality issues.

Expected Evidence of Implementation:

- Capital Procedures updated and signed off at Innovative Environments Group 8 November 2024
- Reference booklet CP4.3 Capital Strategy

Theme: Contractual

Control Design

High Priority

Officer: Head of Capital
Date: November 2024

Objective 3: Selection and Appointment	**Reasonable**

Compliance with SFIs and procurement regulations were observed when selecting contractors/advisers. Monthly meetings between the THB and NWSSP Procurement Services reviewed pipeline projects, resource needs, and other associated project issues, which was considered positive practice.

Various procurement routes were utilised at our sample of 10 projects, including open tender, single tender action, and utilisation of various national frameworks. Documentation was appropriately maintained with positive engagement undertaken by Estates and Capital staff with NWSSP Procurement Services. The single tender action process was appropriately applied at the one instance observed. However, inconsistencies were noted at the procurement strategies within the respective Project Initiation Documents. For example, when frameworks were used, the rationale for direct awards versus mini competition was not always clearly documented. Both methodologies were permitted under the framework, but clear documentation was necessary to demonstrate that value for money was achieved.

Monitoring and reporting processes were clear, with an annual procurement activity report provided by NWSSP Procurement Services and reviewed by the THB's Innovative Environments Group (latest report 2022/23 as delays had been noted for the 2023/24 version). However, improved tracking and monitoring was needed of the action/improvement areas noted within the report.

	Key Findings	Risk & Impact	Agreed Management Action
2	**Consistency in Procurement Strategy approach** A key document to be completed was the Project Initiation Document (Form CP2.1), with Section 5 dedicated to outlining the procurement strategy to be applied at individual projects. From the sample of 10 projects, the detail provided within the procurement strategy section varied significantly. For example, one contained extensive information on compliance with the SFIs through competitive tendering. In contrast, another simply stated that a contractor would be appointed using the Welsh Procurement Alliance framework, without further explanation on how Value for Money would be attained. In the latter instance, there was no explanation of whether a mini-competition or direct award would be applied, nor any rationale provided to justify the selected approach.	Inconsistencies in approach could potentially lead to not optimising supplier selection and less value for money being achieved.	When Frameworks have been used, the appropriate rules of appointment have been consistently followed and are compliant. The Frameworks include tendered, competitive rates but in some instances, a further option for mini competition between Framework Suppliers is possible, which may deliver further cost reduction on the published rates. An explanation of where/why the optional mini tender process was implemented or not will be recorded in the PID, form 2.1. Expected Evidence of Implementation: • Suitable completion of the Procurement Strategy form in the PID.
		Medium Priority	Officer: Head of Capital Date: November 2024
	Theme: Planning, Delivery & Deadline Management	Control Operation	

3	**Monitoring and Reporting** Annual procurement activity reports had been produced for 2021/22 & 2022/23 that documented e.g. 1. Quotation Activity Schedule and Conformance Review. 2. Tender Activity Schedule. 3. Single Tender Waiver Activity Schedule. 4. Areas for Action / Improvement. However, there had been a delay in producing the 2023/24 report, accordingly it was not available for review. The audit did not identify any formal tracking or monitoring of any improvement areas identified at the 2022/23 report. The reports could be improved by providing a year-on-year comparison of supplier spending e.g. there was no cumulative comparison of awards from frameworks, which could increase assurance.	Improvements to procurement processes may not materialise due to lack of proactive monitoring.	The 2023/24 Procurement Annual Report was received on 8 November 2024. An Action Plan will be created based on Areas for Improvement recommendations and this will be reviewed with NWSSP-Procurement Services during routine Procurement meetings. Expected Evidence of Implementation: • Action Tracker developed which will be a fixed agenda item for the Estates / NWSSP Procurement meetings
		Medium Priority	Officer: Associate Director Capital, Estates and Facilities Date: November 2024
	Theme: Reporting	Control Design	

Objective 4: Value for Money and Award	**Reasonable**

Within our sample of projects, appropriate pre-tender estimates had been prepared prior to market testing. This process ensured that a baseline cost estimate was obtained; these costs were included within the project request forms that were reviewed/ approved at the THB's Capital Control Group. This is seen as positive practice and contributes to the setting of realistic financial expectations and for future benchmarking, thereby facilitating effective financial planning.

Following market testing, technical and financial vetting was conducted to ensure that all potential contractors met the necessary standards. This vetting included checks such as public liability insurance, waste carrier licenses, and other relevant certifications. These measures were key to mitigating risks and ensuring that only qualified and compliant contractors were considered. Formal adjudication reports, detailing the evaluations undertaken and the recommendations for awarding contracts, were prepared and signed off at an appropriate level within the THB. This formal process ensured transparency and accountability in the decision-making process.

However, key findings 1 and 3 have an impact on demonstrating effective value for money arrangements. These findings should be referenced when considering the assurance rating of this objective, as they provide evidence supporting a reasonable assurance rating.

Objective 5: Document Retention			**Reasonable**
Management advised that significant record retention improvements have been made, largely due to the implementation of a standardised approach to managing project files. By adopting this method, good consistency/ quality of documentation was observed across all projects sampled - streamlining the process of tracking project progress and demonstrating compliance; but also enhancing transparency and accountability. Contracts that were in place (at 4 of the 10 sampled projects) had been stored in lockable cabinets, ensuring they were secure yet easily accessible to respective project managers when needed. However, it was noted that neither the Capital (nor other) Procedures documented the retention periods adopted within the THB's Information Governance procedures. This omission means there was no clear guidance on how long construction contracts should be retained, which could lead to premature disposal of contractual documents.			
Key Findings		**Risk & Impact**	**Agreed Management Action**
4	**Document Retention** Corporately, the THB has adopted the Records Management Code of Practice for Health and Social Care Guidance as part to the destruction of records procedure – requiring that contracts are held for 6 years prior to disposal. The Capital Procedures make no reference to document retention, or the nuances associated with construction contracts executed as a deed/under seal. e.g. the extended liabilities periods of 12 years (as a minimum) or the lifetime (or disposal) of associated buildings. Other potential amendments to Capital Procedures include: 1. Changes to threshold for the new NHS Building for Wales Framework. 2. Potential updates with regards to the new procurement regulations (currently effective February 2025). This may include further engagement with NWSSP Procurement Services. 3. Wider publication via the Health Board's SharePoint site.	Clear documentation of retention periods should minimise any potential risk of lost information.	Capital Procedures will be updated to reflect a recommendation to retain the Project File for the lifetime of the building as part of the Health & Safety File CDM requirement. It was not considered viable or economic in terms of resource to periodically (6 years, 12 years, etc.) visit the Project File to abstract elements which *could* be deemed to be eligible for destruction, particularly as this would need to be undertaken at a management level. Expected Evidence of Implementation: • Capital Procedures updated and signed off at Innovative Environments Group 8 November 2024 • Section 5.4 Completion Requirements reflects the updated guidance on document retention period
		Medium Priority	Officer: Head of Capital Date: November 2024
	Theme: Policies & Procedures	Control Operation	

Appendix A

Assurance Opinion

Substantial

Few matters require attention and are compliance or advisory in nature.

Low impact on residual risk exposure.

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Limited

More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

Unsatisfactory

Action is required to address the whole control framework in this area.

High impact on residual risk exposure until resolved.

Advisory

Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate.

These reviews are still relevant to the evidence base upon which the overall opinion is formed.

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Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence presents of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

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Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership]

Energy Management

Final Internal Audit Report

2024/25

Powys Teaching Health Board

Reasonable Assurance

Contents

Review Reference	PTHB-SSU-2425-25
Fieldwork	July - September 2024
Executive Sign Off	5th December 2025
Audit Committee	9th January 2025
Executive Lead	Pete Hopgood
Head of Internal Audit	Huw Richards
Deputy Head of Internal Audit	Eifion Jones

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Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

Noting rising costs of energy, effective management and control of energy costs has been risk assessed as an area of potential benefit for audit.

Overview

The Teaching Health Board's (THB's) energy consumption represents 2.3% of the NHS Wales total, with costs of circa £1.0m for gas and circa £1.0m for electricity reported for 2023/24.

Energy is procured centrally on behalf of NHS Wales by NWSSP: Procurement Services, with new contractual arrangements in place from October 2023.

Appropriate governance arrangements were in place, including an experienced Environment & Sustainability Team, reporting into the Environment and Sustainability governance structure.

We evidenced that the Environment & Sustainability Team had established robust systems for data capture, validation and payments: ensuring that management received comprehensive, accurate and timely data for review.

The THB is in the process of utilising re-fit monies of circa £4m to introduce or upgrade Building Management Systems (BMS) e.g. introduction of BMS at Welshpool Hospital and upgrade at Newtown Hospital.

The move to the new NHS Wales energy contract in 2023 had encountered some issues, including difficulties in providing accurate energy forecasts to participating organisations, and additional resource has been required from within the Energy Team to resolve account queries. Recognising the robust data processes operated at the THB, the impact of the national issues had not been as significant as seen elsewhere.

We have concluded **reasonable assurance** on this area. The matters requiring management attention include:

- Enhancing energy issue reporting through the inclusion of pertinent WEOG/WEG updates.
- Maintaining appropriate THB attendance at the all-Wales Energy group meetings (WEOG/WEG).
- The conducting of site walk-arounds as recommended by HTM07-02 Encode (Part A section 3.5)
- Consideration of additional energy risks for inclusion on the Estate's Risk Register.

Full details of matters arising are detailed within the Findings & Agreed Action Plan.

Scope & Assurance Summary

	Objectives	Related Findings	Assurance
1	Governance - Assurance that key roles had been assigned and responsibilities of key staff were understood. An appropriate forum had been assigned with responsibility and accountability for overseeing Energy efficiency/ consumption.	1	**Reasonable**
2	Contract- Recognising the national contracts in place, to obtain assurance that the Health Board obligations under the national contract arrangements were fully understood and applied.	2	**Reasonable**
3	Data Capture – To ensure that appropriate systems were in place to capture data on energy consumption in a timely manner.		**Substantial**

4	Data Validation – To confirm adequate checks were undertaken to verify the quality/ reliability of the data – with any anomalies fully investigated.		**Substantial**
5	Monitoring and Reporting - To review internal / external monitoring and reporting arrangements, to ensure that anomalies were understood, benchmarking was undertaken where appropriate, and any resulting management action was appropriately tracked.	3	**Reasonable**
6	Energy Awareness - That appropriate training had been established for general and key energy staff focused on increasing awareness of obligations and requirements. Assessment of any other initiatives established to increase awareness e.g. intranet pages, staff circulars, team briefings etc.		**Substantial**
7	Payments - Energy related billing was verified, authorised, and processed in accordance with contractual payment terms.		**Substantial**
8	Risk Management - A review of the systems and controls in place to manage energy-related risks, and assurance that risks were escalated as appropriate – to include evaluation of risk mitigation strategies, ensuring compliance with regulations, and addressing any risk exposure.	4	**Reasonable**

Management Actions

0 High Priority

4 Medium Priority

Themes

Risk Types

Financial Loss

Quality or Safety Issues

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Findings & Agreed Action Plan

Objective 1: Governance Arrangements	**Reasonable**

Overview / Summary of Observations

Powys THB does not have a dedicated energy team. However, various individuals within the organisation, particularly those within the Environment & Sustainability Team, handled energy-related responsibilities. This team fulfils many obligations, such as attending and engaging in Welsh Energy Operational Group (WEOG) meetings, liaising with energy suppliers, collating and analysing energy consumption data, and providing reports on usage for both internal stakeholders and external bodies, including NWSSP: Specialist Estates Services and Welsh Government.

Energy performance was reported by the energy team during the monthly Buildings and Biodiversity Group meetings, a sub-group of the Environment and Sustainability Group (ESG). Although Powys THB does not have a dedicated energy forum, as the organisation does not believe its size warrants one, the Buildings and Biodiversity sub-group includes a standing agenda item on energy.

A review of the meeting minutes from January to June 2024 demonstrated that updates from the Buildings and Biodiversity Group were a standing agenda item. These updates were provided verbally by the Chair of the BBG, together with a 'Compliance Highlight Report,' which detailed key risks and actions required related to energy and water

	Key Findings	Risk & Impact	Agreed Management Action
1	**Energy themed reporting** The Buildings and Biodiversity group meetings include a standing agenda item covering energy. This included a verbal update on energy issues and discussion within the group. The periodic presentation of a report detailing energy usage across the estate was also noted This in turn was reported through the ESG with an update from the Chair of the BBG and the submission of a Compliance Highlight Report. All the above are indicative of an established and functioning reporting process, contributing to good overall governance. It was noted however that this could be enhanced by the inclusion of an update from those attending the WEOG meetings of key issues and salient points of interest to PTHB.	Gap in a shared overall understanding of energy issues, in particular contractual which may include risk to the HB from both a financial and supply perspective.	Management Action: Welsh Energy Operational Group meeting update is now a standard agenda item at the Utilities Management Group. Issues will be escalated by exception to the Environment and Sustainability Group/Innovative Environments Group, as required. Expected Evidence of Implementation: • Agenda and minutes of Utilities Management Group.
		Medium Priority	Officer: Environmental and Sustainability Manager. Date: November 2024
	Theme: Governance	Control Operation	

Objective 2: Contracts			**Reasonable**

Overview / Summary of Observations

In October 2023, the THB entered a new all-Wales NHS energy contract with Crown Commercial Services (CCS), managed by NWSSP: Procurement Services. This change was due to the existing supplier exiting the market, citing volatility since 2021.

Two new central governance forums were initiated to oversee the arrangements:

- Welsh Energy Group (WEG) – Responsible for the strategy for energy procurement and determining basket choices from the CCS framework. Membership included Directors of Finance representing each organisation.
- Welsh Energy Operational Group (WEOG) – Responsible for establishing a common model for supplier management. Membership included operational energy and finance colleagues from member organisations.

Internal Audit reviewed these arrangements in January 2024, determining Substantial Assurance.

The implementation of the new CCS contract has seen issues across NHS Wales, both in the closure of the British Gas accounts and the commencement of relationships with the new gas and electricity suppliers under the CCS framework. These difficulties have impacted all organisations, to varying degrees, e.g. the availability of accurate data (forecasting and validation of invoices) and input of additional resource to resolve issues.

Handover issues were addressed centrally by WEOG. THB's active participation in WEOG meetings ensured they influenced decision-making and supplier management effectively.

Key Findings		Risk & Impact	Agreed Management Action
2	**Attendance at WEOG and WEG meetings** Whilst the THB has on the whole been well represented at WEOG and WEG meetings held in the past 10 months, with good engagement noted from those in attendance from the THB, there were a small number of occasions where finance representation was not observed. This is more of a concern at the WEG meetings where opinions are canvassed and decisions made regarding contracts, and the corresponding financial and service implications. Powell, Bethan 03/02/2025 16:55:30	The THB do not have the requisite level of staff attendance at WEOG/WEG meetings, resulting in the THB not being represented in potentially key decision-making discussions.	Management Action: PTHB Environment and Sustainability represent the organisation at the Wales Energy Operational Group. Finance will provide representation at Welsh Energy Group (WEG) meetings where decisions with financial implications are made. Expected Evidence of Implementation: • Finance attendance at WEG meeting week commencing 18 November 2024.
		Medium Priority	Officer: Finance Business Partner Date: November 2024
Theme: Communication & Engagement		Control Operation	

Objective 3: Data Capture — Substantial

Overview / Summary of Observations

The THB's Environment & Sustainability Team maintained a utility spreadsheet populated manually on a monthly basis with data received from suppliers and independently from manual meter reads. The established processes guaranteed that a comprehensive data set was available for input into the energy management system, facilitating prompt and precise reporting for various objectives, such as financial budgeting. Nevertheless, the dependency on manual data gathering and entry was not considered time efficient.

Whilst there was some degree of sub-metering at the larger sites, this was limited, and data analysis tended to be at site level unless specific concerns required the energy team to investigate a specific meter. Management advised that it was not affordable to change the sub-metering arrangements, reliance was therefore on the BMS systems for more detailed monitoring.

Noting some THB premises were leased to third parties (predominantly other NHS organisations), the THB had an established process to recharge utility costs in an agreed apportioned manner.

The THB were in the process of utilising re-fit monies circa £4m to introduce or upgrade BMS e.g. introduce BMS at Welshpool Hospital and upgrade at Newtown Hospital. This would improve monitoring capabilities and was anticipated to positively impact energy consumption levels.

Objective 4: Data Validation — Substantial

Overview / Summary of Observations

The THB lacked dedicated software for managing energy consumption data, setting it apart from other NHS organisations in Wales. This however is understandable given the size of the organisation and uniqueness amongst the other Health Boards in not operating larger district general hospitals.

However, the spreadsheets as maintained had been established for several years, with the small estates team fully conversant with their application. Audit testing did not identify any obvious errors at the operation of the spreadsheets. Reliability of data was very much based on the experience and vigilance of the team member (s) maintained the relevant spreadsheet.

The THB also demonstrated a robust authorisation process for the approval of utility invoices prior to their submission to NWSSP for payment. The sample of invoices reviewed having been digitally stamped with payment account numbers, and signatures; checked and authorised appropriately by the two recognised signatories. Also noting the signatories routinely sample the invoices received and check before approval.

Objective 5: Monitoring and Reporting	**Reasonable**

Overview / Summary of Observations

The audit included two site visits, to Newtown and Welshpool Hospitals to assess for any visible instances of energy inefficiency. General good practice was observed at both sites.

At the time of review, limited BMS controls were operating across the THB estate, for example there was a limited function BMS capability at Newtown and Bronllys hospitals and no BMS capability at Welshpool hospital. Installing/ updating the BMS was a specific action included within the THB's Decarbonisation Action Plan. The THB were in the process of utilising re-fit monies (circa £4.2m) to address the same.

The energy team generated monthly energy consumption reports for individual sites using excel. These were distributed and displayed on site noticeboards. However, the lack of sub-metering limited the granularity of insights. It was noted that the THB, in consultation with colleagues at other Health Boards, will be seeking to utilise more advanced reporting functionality through the adoption of additional custom excel reporting features.

The THB conducted six facet surveys in early 2024, there were also annual mandatory DEC reviews completed along with ISO14001 annual audits. Whilst noting the assurance these provide; energy walk arounds as recommended within HTM 07-02 Encode Part A were not currently undertaken.

With the support of NWSSP SES, the THB has made efforts to gather meaningful benchmarking data, including comparisons with wider health organisations in rural areas of England. However, no relevant comparable organisational data has been identified thus far.

Key Findings		Risk & Impact	Agreed Management Action
3	**Site walk arounds** Site walk-arounds are recommended by HTM07-02 Encode (Part A section 3.5). The guidance notes that these should be undertaken at least once per year, or ideally once in the summer and once in the winter. These walk arounds not only allow first hand observation of where energy is being used but also offer an opportunity to raise the profile of energy awareness with Health Board colleagues. This is particularly pertinent for PTHB, as understandably, resources, structure and geographical spread of the organisation mean that having dedicated energy champions in post at various locations is not feasible.	Visible matters of energy inefficiency are not identified.	Management Action: 'Site walkaround' energy audits will be included in the ISO 14001 annual audit schedule. The audits will be conducted by the Environment and Sustainability team with outcomes reported back to the Utilities Management Group where actions will be allocated and monitored. Expected Evidence of Implementation: • Audit Plan with energy audits commencing November 2024
	Theme: Financial Management & Control	**Medium Priority** Control Operation	Officer: Environmental and Sustainability Manager. Date: November 2024

Objective 6: Energy Awareness — Substantial

Overview / Summary of Observations

In assessing energy awareness measures, it is recognised that the Decarbonisation agenda (separately audited in 2023/24) now encompasses targeted activity for staff communication and training. The Decarbonisation Action Plan (DAP) and progress against the same has not been re-audited at this review.

The THB do not have dedicated Energy Champions, lacking the available resources to fulfil this extra obligation. However, the THB seeks to address this indirectly with their recognised focus on environment & sustainability.

It was noted that the THB had a well-established commitment to meeting environmental and sustainability targets, with an established DAP in place. The THB has a hierarchy of environmental oversight through groups such as the ESG, BBG and the Innovative Environments Group, the latter of which feeds directly into the Finance and Performance Committee (a subcommittee of the Board).

Whilst energy-related training modules were available on ESR, it was noted that these were not mandatory. This issue was previously addressed at the Decarbonisation Audit conducted in 2023/24, where it was noted that staff take-up of the module had been low. However, acknowledging that the THB through its ESG meeting was seeking to target improvements in this area, acknowledging that improved staff training would better inform future decision making in relation to energy awareness/ promotion.

Objective 7: Payments — Substantial

Overview / Summary of Observations

Audit testing identified a robust process of invoice review, data input and validation by the Environment & Sustainability team. All invoices sampled for testing were confirmed to have been correctly entered into the THB's energy spreadsheets (excel). All received invoices were electronically annotated to ensure they were reviewed and approved for payment.

Individual invoices were processed against an annual call-off purchase order recorded in Oracle at the beginning of the year, which was based on the THB's projected energy costs.

The THB had not incurred any late payment fees in the period reviewed as part of this audit. Testing noted that invoices were processed promptly and sent onto AP within a few days of receiving.

Objective 8: Risk Management	**Reasonable**

Overview / Summary of Observations

The latest Corporate Risk Register, as reported to the Board in September 2024, was reviewed for any reference to energy risks. The following were noted:

- Corporate Risk Register (CRR09) noted the risk that "*The care provided in some areas is compromised due to the health board's estate not being fit for purpose"*. This risk was assessed as having a risk rating of '16' includes achieving the DAP with limited resource.
- CRR 01 - Financial sustainability risk, may contain some element of energy costs, though not explicitly detailed (currently scored 16).
- CRR 011 - National power outage (risk rated as 20). This is a national level risk included by all public sector organisations.

Aside from being reviewed and approved at the Board the Corporate Risks as identified are an agenda item at the respective board sub-committees with responsibility for individual risk areas. For CRR09 this was the responsibility of the Delivery & Performance Committee.

Energy risks that could affect the DAP were reported to, and overseen by, the Buildings and Biodiversity subgroup, the Environment & Sustainability Group and ultimately the Innovative Environments Group.

At a divisional level the Estates Department risk register included a risk (3) 'Fit for Purpose Estate' which primarily addresses the availability of capital and revenue funding and the risk to the THB in meeting its objectives; narrative added in a review in March 2024 noted the risks posed by rising energy costs.

Key Findings		Risk & Impact	Agreed Management Action
4	**Energy Risk Reporting** It was recognised that risks pertinent to energy management measures were captured as part of the Decarbonisation Programme (DAP) governance process. Additionally, there was narrative within the Estates risk register noting Energy cost pressures as part of revenue implications for estates. However, whilst noting the same, during the audit, a number of energy management related risks had been noted and discussed that may warrant formal assessment, including the new All-Wales energy contract, which continued to cause disruption to process and available data.	If not identified and assessed, risks may not be appropriately managed.	Management Action: Feedback and identification of risks and issues from Welsh Energy Operational Group and Welsh Energy Group will be reported via the agenda item at the PTHB Utilities Management Group and escalated by exception to the Environment and Sustainability Group/Innovative Environments Group, as required. Expected Evidence of Implementation: • Agenda and minutes of Utilities Management Group.
		Medium Priority	Officer: Environmental and Sustainability Manager. Date: November 2024
	Theme: Risk Management	Control Operation	

Appendix A

Assurance Opinion

Substantial

Few matters require attention and are compliance or advisory in nature.

Low impact on residual risk exposure.

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Limited

More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

Unsatisfactory

Action is required to address the whole control framework in this area.

High impact on residual risk exposure until resolved.

Advisory

Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate.

These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Disclaimer

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The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management of Powys Teaching Health board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present, of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership]

Delivery and Performance Committee 2024-25

Theme	Item Title	May 07/05/2024	June 27/06/2024	August 29/08/2024	October 22/10/2024	December 05/12/2024	February 06/02/2025
Governance	Minutes of previous meeting	✓	✓	✓	✓	✓	✓
Governance	Declaration of Interests	✓	✓	✓	✓	✓	✓
Governance	Action Log	✓	✓	✓	✓	✓	✓
Governance	Committee Reflections	✓	✓	✓	✓	✓	✓
Governance	Committee Risk Register	✓	✓	✓	✓	✓	✓
Governance	Annual Work Programme	✓					
Governance	Work Programme (updated through year)		✓	✓	✓	✓	✓
Governance	Annual Assessment of Committee Effectiveness						✓
Governance	Committee Annual Report (including IC elements)	✓					
Governance	Review of Terms of Reference						✓
Performance	Integrated Quality and Performance Report	✓	✓	✓	✓	✓ **Mth 7 scorecard**	✓Pwk#<#vfruhfdug
Performance	Annual Delivery Progress Report			✓ **Q1**	✓ **Q2**		✓ **Q3**
Finance	Finance Report	✓	✓	✓	✓	✓	✓
Finance	Savings - (Six monthly report on Continuing Heath Care costs)			✓			✓
Finance	Variable Pay (Escalated issue)						
Annual Reporting	Draft Performance Report	✓					
Innovative Environments	Capital Programme Delivery					✓	
Innovative Environments	Capital and Estates Compliance Report						✓
Innovative Environments	Capital and Estates Strategy monitoring						✓
Innovative Environments	Capital Pipeline Overview					✓	
Innovative Environments	Powys PSB Climate Working Group Update			✓			
Primary Care	GMS		✓	✓	✓		
Primary Care	GDS		✓			✓	
Primary Care	Out of Hours	☒	✓				✓
Primary Care	Community Pharmacy Annual Report					✓	
Digital First	Annual Plan	✓					
Digital First	Monitoring Report			✓	✓		
Digital First	IT Infrastructure and Asset Management (update against audit report and progress)	✓					
Audit Reports	Any Internal Audit/Wales Audit reports received - for information	N/A	N/A	N/A	N/A	N/A	N/A
Audit Rec Monitoring	Corporate Risk Register -(Cyber security)-In Committee	✓	✓	✓	✓		
Communications	Comms and Engagement Report			✓		✓	
	Six monthly report on catering services		✓				✓
	Organisational Escalation Status Presentation		✓	✓	✓	✓	✓

Powys Teaching Health Board Glossary (January 2025)

Acronym	
ADoECP	Associate Director of Estates, Capital & Property
CEO	Chief Executive Officer
DCG	Director of Corporate Governance
DIT	Director of Improvement & Transformation
EMD	Executive Medical Director
ED PH	Executive Director of Public Health
ED P&C	Executive Director of People and Culture
ED PP&C	Executive Director of Planning, Performance and Commissioning
ED FCSS	Executive Director of Finance, Capital & Support Services
ED AHPHSD	Executive Director of Allied Health Professions, Health Sciences and Digital
ED NQW&FH	Executive Director of Nursing, Quality, Women and Family Health
EDPCCMH	Executive Director of Primary Care, Community & Mental Health
AFC	Agenda for Change
AHPs	Allied Health Professionals
ALN	Additional Learning Needs
AO	Accountable Officer
ARAC	Audit, Risk and Assurance Committee
ASM	Accelerated Sustainable Model
ABUHB	Aneurin Bevan University Health Board
AR	Audit Recommendations
AGW	The Auditor General for Wales
BAF	Board Assurance Framework
BMA	British Medical Association
BCUHB	Betsi Cadwaladr University Health Board
CAAP	Clinical Associate in Applied Psychology
CAMHS	Child and Adolescent Mental Health Services
CEMT	Chief Executive Management Team
CHC	Continuing Health Care
CIW	Care Inspectorate for Wales
CLIP	Collaborative Learning in Practice
CNO	Chief Nursing Officer
CPD	Continued Professional Development
CPR	Child Practice Review

CRR	Corporate Risk Register
CSP	Clinical Service Plan
CV	Curriculum Vitae
CWMPAS	Mid and West Wales Regional Safeguarding Adults Board
CYSUR	Mid and West Wales Regional Safeguarding Children Board
CCN	Childrens Community Nursing
CTMUHB	Cwm Taff Morgannwg University Health Board
CVUHB	Cardiff and Vale University Health Board
D&P	Delivery and Performance Committee
DCG	Delivery Co-ordination Group
DHCW	Digital Health and Care Wales
DNA	Did not Attend
DATIX	Incident Management System
DPA	Data Protection Act
DGH	District General Hospital
DToC	Delayed Transfer of Care
EASC	Emergency Ambulance Services Committee
EOG	Executive Oversight Group
EMRTS	Emergency Medical Retrieval & Transfer Service?
ESR	Electronic Staff Record
EOY	End of Year
FOI	Freedom of Information
FFT	Friends and Family Test
FTE	Full Time Equivalent
FBC	Full Business Case
GIRFT	Getting It Right First Time
GDS	General Dental Services
GMC	General Medical Council
GMS	General Medical Services
GP	General Practitioner
H&S	Health and Safety
HCA	Health Care Assistant
HCS	Health and Care Standards
HCSW	Health Care Support Worker
HEIW	Health Education and Improvement Wales
HIW	Healthcare Inspectorate Wales
HPF	Healthcare Professionals Forum
HDUHB	Hywel Dda University Health Board
ICF	Integrated Care Funding

IEN	Internationally Educated Nurse
IG	Information Governance
IM	Independent Members
IMTP	Integrated Medium Term Plan
IP&C	Infection Prevention and Control
IQPF	Integrated Quality Performance Framework
IQPG	Integrated Quality & Performance Group
IQPR	Integrated Quality Performance Report
IT	Information Technology
JAG	Joint Advisory Group (on Gastrointestinal Endoscopy)
JCC	Joint Commissioning Committee
JD	Job Description
JET	Joint Executive Team
JIPCA	Joint Inspection of Child Protection Arrangements
JLT	Joint Leadership Team (PTHB and PCC)
JR	Judicial Review
KPI	Key Performance Indicator
LoF	League of Friends
LMC	Local Medical Committee
LPF	Local Partnership Forum
LTA	Long Term Agreement
LHB	Learning Health Board
LA	Local Authority
MDTs	Multi-Disciplinary Teams
MEG	Medical E-Governance System
MEG	Main Expenditure Group
MH	Mental Health
MIU	Minor Injury Unit
MOU	Memorandum of Understanding
MOA	Memorandum of Agreement
MSK	Musculoskeletal
MD	Ministerial Direction
NHSE	National Health Service England
NHS	National Health Service
NHSWE	NHS Wales Executive
NICE	National Institute of Health and Clinical Excellence
NRI	Nationally Reportable Incidents
NWSSP	NHS Wales Shared Services Partnership
OCP	Organisational Change Process

OOC	Out of County
OOH	Out of Hours
OSCE	Objective Structured Clinical Examination
OT	Occupational Therapy
OBC	Outline Business Case
PA	
PADR	Personal Appraisal Development Review
PAVO	Powys Association of Voluntary Organisations
PCC	Powys County Council
PEQS	Patient Experience, Quality and Safety Committee
PHE	Public Health England
PHW	Public Health Wales
PPPH	Planning, Partnerships and Population Health Committee
PSB	Public Service Board
PSOW	Public Services Ombudsman for Wales
PTHB	Powys Teaching Health Board
PTR	Putting Things Right
QA	Quality Assurance
RaTS	Remuneration and Terms of Service Committee
RCN	Royal College of Nursing
RN	Registered Nurse
RPB	Regional Partnership Board
RIIC	Research, Innovation & Improvement Coordination
RISP	Radiology Information System Procurement
RPB	Regional Partnership Board
RTT	Referral to Treatment
RJAH	Rhobert Jones Agnus Hunt
RTS	Routemap To Sustainability
RIF	Regional Investment Fund
Q1 Q2 Q3 Q4	Quarter 1 (April, May, June), Quarter 2 (July, August, September), Quarter 3 (October, November, December), Quarter 4 (January, February, March)
SAR	Subject Access Request
SAS	Specialty and Specialist
SBAR	Situation, Background, Assessment, Recommendation
SLA	Service Level Agreement
SOC	Strategy Outline Case
SOP	Standard Operating Procedure
SBUHB	Swansea Bay University Health Board
SaTH	Shrewsbury and Telford Hospital NHS Trust

SPB	Strategic Programme Board
SRO	Senior Responsible Owner
TI	Targeted Intervention
ToR	Terms of Reference
TRAC	Online Recruitment Management System
T&V	Transformation & Value
VERS	Voluntary Early Release Scheme
WAST	Welsh Ambulance Services NHS Trust
WPOCT	Welsh Point of Care Test System
W&C	Workforce and Culture Committee
WCCIS	Welsh Community Care Information System
WG	Welsh Government
WNB	Was Not Brought
WOD	Workforce and Organisational Development
WHC	Welsh Health Circular
WHSSC	Welsh Health Specialised Service Committee
WTE	Whole Time Equivalent
WVT	Wye Valley Trust
WPAS	Welsh Patient Administration System
YTD	Year to Date